ORIGINAL

Donald F. Carey
Robert D. Williams
QUANE SMITH LLP
2325 West Broadway, Suite B
Idaho Falls, Idaho 83402-2948
Telephone: (208) 529-0000

Attorneys for Defendant Continental Casualty Company

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

CHRIS J. DENNISON,

Plaintiff,

vs.

CONTINENTAL CASUALTY COMPANY an Illinois corporation; CNA GROUP LIFE ASSURANCE COMPANY, a wholly owned subsidiary of Continental Casualty Company, RURAL TELEPHONE COMPANY, an Idaho Corporation

Defendants.

Case No. CIV 02-507-S-LMB

DEFENDANT CONTINENTAL CASUALTY COMPANY'S AFFIDAVIT/CERTIFICATION

STATE OF Florida)
:ss
COUNTY OF Orange)

I, Doris Gloss, being first duly sworn on oath deposes and says:

31

1. That I am an employee of Continental Casualty Company and am responsible for the decision to approve or deny Policy Benefits regarding Chris J. Dennison, Claim No. 2395634. I am familiar with the documents reviewed in determining the eligibility of Plaintiff, Chris J. Dennison, to receive benefits. I certify that those records which are attached as Exhibit "A" constitute a true and correct copy of the administrative record relating to Plaintiff's claim for benefits pursuant to the Employee Retirement Income Security Act of 1974 (ERISA) as amended 29 USC § 1001, *et seq.*

2. Attached as Exhibit "B" is a true and correct copy of the Group Long Term Disability Policy, number SR-83116494, along with all of the amendments, attachments and declarations thereto, under which policy Plaintiff claimed benefits in the above entitled matter.

Further your AFFIANT saith not.

Continental Casualty Company, by

Doris Gloss

Printed name: Doris Gloss

Title: Appeals Claim Specialist

SUBSCRIBED AND SWORN to me this 14th day of August, 2003.

Mindy K. Elfand

Notary Public

Mindy K. Elfand
Commission #DD159126
Expires: Oct 17, 2006
Bonded Thru
Atlantic Bonding Co., Inc.

Residing at: _____

My Commission Expires: _____

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 19th day of August, 2003, I served a true and correct copy of the foregoing DEFENDANT CONTINENTAL COMPANY'S AFFIDAVIT /CERTIFICATION IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT by:

David E. Comstock, Esq.
COMSTOCK & BUSH
800 West Idaho, Suite 300
P.O. Box 2774
Boise, Idaho 83701
Attorneys for Plaintiff

[✓] U.S. Mail, postage prepaid
[ ] Hand-Delivered
[ ] Overnight Mail
[ ] Facsimile @ 208/344-7721

Robert A. Anderson, Esq.
Phillip J. Collaer, Esq.
ANDERSON, JULIAN & HULL, LLP
250 South Fifth Street, Suite 700
P.O. Box 7426
Boise, Idaho 83707-7426
Attorneys for Defendant Rural Telephone Company

[✓] U.S. Mail, postage prepaid
[ ] Hand-Delivered
[ ] Overnight Mail
[ ] Facsimile @ 208/344-5510

Robert D. Williams


EXHIBIT
A

Claim Analysis Record

Claim Number:	2395634112	Date of Notice:	2/19/02 KC
Claimant Name:	CHRIS DENNISON	Claimant Telephone:	208-658-0097
Employer Contact:	JAMES MARTELL	Employer Telephone:	208-366-2614

Last Date Worked:	First Date of Treatment	Date of Loss	Date of Birth:	Age at DOL:	Is Claimant Working?
2/7/02	1/29/02	2/8/02	10/9/50	51	☐ Yes ☑ No

Occupation: Controller Diagnosis: 724.2 Lumbago s/p Back Surgeries

	LTD	SPECIAL HANDLING
Contract Reviewed:	☒ Yes ☐ No Initials: BB	
Policy Number:	83116494	
Salary:	6129.00	
Elimination Period:	90	
Benefit:	67 % 9000 max	
Class:	1	
Location:	—	
Maximum Payable Period:	Own Occ MPP: 24m.	
	Any Occ MPP: Retirement Age	
Premium Paid Thru Date:	1-1-02	
Contract Type	☐ PDI ☑ SBDI	
Group EDOC	8/1/99	
COC:	☐ Yes ☑ No	
Date of Hire:	7/1/97	
	☒ full time ☐ part time	
Rehire Date:	—	
Waiting Period:	30	
Minimum # of Work Hrs:	30	
Employee's EDOC:	8/1/99	
Contribution Percentage	ER% 100 EE% —	
	(Pre) ~~Post~~	
100% Participation Required?	☒ Yes ☐ No ☐ N/A	
Enrollment Card Received:	☐ Yes ☑ No	
Date Card Signed:	—	
Late Enrollee:	☐ Yes ☒ No	BSD 5/9/02
Late App on File:	☐ Yes ☒ No	$ 4106.43
Mis Rep Issue:	☐ Yes ☒ No	
Proof of Premium Received:	☒ Yes ☐ No ☐ N/A	

Revised 8/15/2001

INSURANCE IN TOUCH WITH BUSINESS

PO Box 946710 Maitland FL 32794

Doris Gloss RN
Appeals Committee Member
Telephone 800-303-9744 x6272
Facsimile 407-919-6574

June 24, 2002

Chris Dennison
9975 W Hollandale Drive
Boise, ID 83709

Claim Number: 2395634
Policy Number: 83116494
Underwritten by: Continental Casualty Company
Services provided by: CNA Group Life Assurance Company

Dear Mr. Dennison,

Appeals completed a comprehensive review of your long-term disability claim as requested. Our review is based on the medical evidence that was submitted to CNA and was relied upon to conclude the determination of long-term disability benefits. After review of your file, in its totality, we must reaffirm the denial of benefits based on the following medical evidence and policy provisions. Appeals agreed with the intent, content, and conclusion brought forth by the denial letter written on 3/15/02 and some information may not be repeated.

According to the policy provisions: "Disability" means that during the Elimination Period and following 24 months, Injury or Sickness causes physical or mental impairment to such a degree of severity that You are:

1. continuously unable to perform the Material and Substantial Duties of Your Regular Occupation; and
2. not working for wages in any occupation for which You are or become qualified by education, training or experience."

According to the information within your file, you ceased work on 2/7/02 due to back pain.

Dr. Frizzell filled out a physician's statement listing your diagnosis failed back syndrome, status post lumbar, and cervical surgeries. You complained of constant neck and back pain from multiple past surgeries. Dr. Frizzell listed your physical limitation as no lifting, pushing/pulling over 5 pounds. No prolong sitting or standing and only occasional bending and twisting.

Your employer submitted a job activity statement listing the physical requirement for the occupation as a Controller. The physical requirements that were provided were listed as follows: sitting for 10 to 12 hours with 1 to 2 hours of standing and walking per day. Occasional lifting boxes containing per and records from 20 to 50 pounds were required. You employer stated that lifting boxes were not a necessary part of your occupation and lifting could be accommodated.

A cervical spine x-ray was performed on 1/29/02 showing a solid appearing fusion from C5-6 and mild to moderate disc degeneration. The spine was in normal alignment with no fractures or subluxation and the prevertebral soft tissues were unremarkable. A lumbar spine x-ray was also performed on the same date that showed mild to moderate degenerative disk disease, no spondylolysis or spondylolisthesis.

An MRI of the entire spine was performed on 2/4/02 that the cervical spine showed there was no evidence of disk herniation, degenerative changes and posterior disk bulges were identified; however the cervical cord maintained normal size, shape and signal throughout. The thoracic spine showed a normal signal with mild degenerative changes without evidence of spinal stenosis or neural foraminal narrowing. The lumbar spine showed mild changes of degenerative disk disease and small postural protrusion with mild to moderate stenosis without herniation.

Dr. Frizzell submitted a correspondence dated 5/21/02, indicating that you have been under his care for low back and cervical neck surgeries and that you are disabled for your spine condition. Dr. Frizzell noted that you are not able to work with accommodations and you have rheumatological disease with positive lupus studies. On 3/21/02, Dr. Fizzell submitted a positive titer for anti-nuclear. The laboratory noted that a positive ANA result may be seen in a variety of diseases and healthy individuals. Its interpretation depends on clinical findings and other laboratory data. An ESR was also performed (a nonspecific test used to detect illness associated with acute and chronic infection or inflation. This test result was normal (2), (normal is 0-20).

While we acknowledge the medical tests may have revealed some abnormal findings; there were no physical examination within your claim file performed by your physicians to correlate clinical findings. Dr. Frizzell provided restrictions in the physician's statement that fell within the material and substantial duties of your occupation as a Controller. Lifting 20 to 50 pounds of boxes containing papers was listed as occasional, which would not be a material and substantial requirement of your occupation. Dr. Frizzell then submitted a correspondence noting that you would not be able to perform your occupation with accommodations; however, he did not submitted any evidence to support a functional impairment that would prevent you from performing your occupation.

Dr. Firzzell indicated that you also had a history of lupus and submitted a positive titer; however, your ESR (erythrocyte sedimentation rate) rate that would show an inflammatory process occurring within the body was low normal. Please be advised that verification of a condition does not confirm the inability to perform one's occupation, nor does it prove a disability.

Dr. Frizzell submitted a correspondence dated 4/22/02 noted that you were under his care for failed back syndrome and a history of lupus and had multiple surgeries, intractable back, neck and leg pain. Dr. Frizzel further noted that you are disabled from these conditions and were not able to engage in any kind of work. We acknowledge that you may have undergone back and neck surgery from 1997 and 1998, the evidence showed that your fusion was intact and that you had mild to moderated degenerative disc disease. There was no disc herniation or abnormal alignment of the spine noted. While we acknowledge that you would not be able to perform a heavy occupation, the evidence presented within your file does not support a functional impairment that would preclude you from performing the material and substantial duties of your occupation as a Controller.

We are sorry that our ruling could not be more favorable, however, we must abide by the medical evidence and the policy provisions. You have exhausted all of your administrative remedies offered by the appeal committee and your file remains closed. This decision is final and binding.

Sincerely,

Doris Gloss RN
A member of the Appeals Committee

INSURANCE IN TOUCH WITH BUSINESS

PO Box 946710 Maitland FL 32794

Doris Gloss RN
Appeals Committee Member
Telephone 800-303-9744 x6272
Facsimile 407-919-6403

June 25, 2002

Rural & Pend Oreille Telephone Company
Attn: James Martell
704 W. Madison Ave.
Glenns Ferry, ID 83623

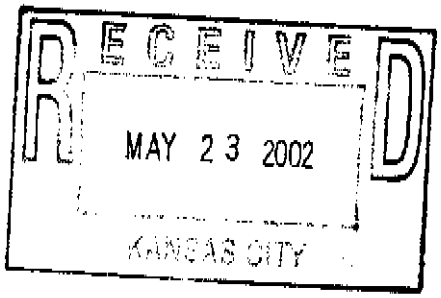
Regarding: Chris Dennison
Claim Number: 2395634
Policy Number: 83116494
Underwritten by: Continental Casualty Company
Service provided by: CNA Group Life Assurance Company

Dear Mr. Martell,

We have completed a comprehensive review of Mr. Dennison's claim file as he has requested in his appeal letter. The medical evidence presented does not support a functional impairment that would preclude Mr. Dennison from performing his occupation. Due to the confidential nature of Mr. Dennison's medical records, we are unable to provide you with a copy of his letter; therefore, this letter will serve to inform you that Appellate committee has upheld the denial.

Sincerely,

Doris Gloss RN
Member of the Appeals Committee



May 2,2002

Mr. Brian Barnum
Disability Benefits Specialist
C.N.A. Insurance
P.O. Box 25939
Overland Park, KS 66225-5939

"SENT VIA FEDERAL EXPRESS"

RE: Appeal of C.N.A. declination of long-term disability benefits, Claim #2395634, Policy #83116494.

Dear Mr. Barnum:

Attached is a letter from R. Tyler Frizzell MD regarding my physical condition and work limitations. Please reconsider my application for long-term disability benefits. Because of my physical limitations, I have not been able to work since February 1, 2002.

Additionally, there are two letters attached from Mr. Mike Richmond, dated March 8, 2002 and March 29, 2002, wherein he states that the Company considers my last day of employment with Rural Telephone Company March 6, 2002. In your letter dated March 15, 2002, you stated that on March 12, 2002 Mr. Richmond said they "will make any reasonable accommodations to accommodate his physical condition". I submit that this offer was without sincerity and contradictory, as evidenced by the date of Mr. Richmond's first letter dated March 8, 2002 and your telephone conversation with him on March 12, 2002. The Company effectively terminated my employment before your conversation with him.

If you have further questions or if there is anything I can do to accelerate the processing of this claim please call me at home, 208-658-0097. Time is of the essence because a delay will cause severe financial hardship. Thank you in advance for your consideration and assistance in this matter.

Best Regards,

Chris J. Dennison, CPA

IDAHO NEUROLOGICAL SURGERY, P.A.

DOUGLAS E. SMITH, M.D.
CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

R. TYLER FRIZZELL, M.D., PH. D.
CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

April 22, 2002

Re: Chris Dennison

TO WHOM IT MAY CONCERN:

Mr. Dennison is under my care for failed back syndrome and a history of lupus. He has had multiple surgeries and intractable back, neck, and leg pain.

It is my opinion that Mr. Dennison is disabled from these conditions and not able to engage in work of any kind.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/egs

222 NORTH SECOND STREET, SUITE 307 • BOISE, IDAHO 83702 • (208) 344-1000 • (800) 733-1989 • FAX (208) 344-1331

RURAL TELEPHONE COMPANY
704 W. MADISON
GLENNS FERRY, IDAHO 83623
(208) 366-2614 • FAX (208) 366-2615

March 29, 2002

Chris J. Dennison
9975 W. Hollingdale Dr.
Boise, ID 83709

RE: Final Pay Summary

Dear Chris:

Below is a summarization of events and outline of your severance from Rural Telephone Company:

Accrued Sick Balance Depleted *(72 hrs)*:	February 13, 2002
Final 401k deduction/deposit:	February 27, 2002
Final payment to 401k loan *(from payroll deduction)*:	February 27, 2002
Earned/Used Vacation Balance Depleted *(120 hrs)*:	March 6, 2002
Separation Date:	March 6, 2002
Life Insurance discontinued:	March 6, 2002
NTCA Health Insurance valid through:	June 30, 2002*

As previously stated (March 8, 2002 letter), Rural Telephone Company will continue to pay your health insurance premiums through the second quarter; June 30,2002*. This date was shown as May 31, 2002 previously. We anticipate at this time, NTCA will be contacting you with COBRA information. In recognition of your service to the Company, Rural Telephone Company will pay the equivalent of 90-days regular pay to assist you during this time of transition from the workforce to a potential long-term disability status. Also, per your request, we have changed your exemptions to 9.

Enclosed you will find a check in the amount of $10,058.99; which represents the balance of your lump sum severance package.

It is important to note that the final payroll deduction for your 401k loan payment was made on February 27, 2002. We suggest you contact Copper Mountain Trust in regard to your options and/or obligations with respect to this loan.

Sincerely,

Michael T. Richmond
General Manager

Enclosure

RURAL TELEPHONE COMPANY
704 W. MADISON
GLENNS FERRY, IDAHO 83623
(208) 366-2614 • FAX (208) 366-2615

March 8, 2002

Chris J. Dennison
9975 W. Hollingdale Dr.
Boise, ID 83709

RE: Separation Notice

Dear Chris:

As of March 6, 2002, your accrued sick leave and 2002 earned vacation time have been depleted and no additional hours are available. Therefore, Rural Telephone Company considers this as your final day of employment and will use March 6, 2002 as your separation/termination date from the Company.

As a courtesy, Rural Telephone Company will continue to pay your health insurance premiums through May 31, 2002. We anticipate at this time, NTCA will be contacting you with COBRA information. Your life insurance benefits are discontinued effective today and there will be no further 401k deductions/deposits.

Enclosed you will find a check in the amount of $1,052.15; which represents the balance of earned/used vacation time.

We are structuring a severance package and hope to meet with you sometime next week to discuss it.

Hope all is well with you. We look forward to visiting with you soon. If you have any questions in the meantime, please don't hesitate to contact me.

Sincerely,

Michael T. Richmond
General Manager

Enclosure

FAX TRANSMISSION

MEULEMAN & MILLER LLP
960 BROADWAY AVE., SUITE 400
POST OFFICE BOX 955
BOISE, IDAHO 83701
(208) 342-6066
FAX (208) 336-9712

	PAGES*	FAX NUMBER	TIME
TO: Tabatha Kirke	6	913-661-7777	

FROM: Katherine W. Dennison

DATE: May 20, 2002

RE: Chris J. Dennison, claim no.: 2395634, policy no.: 83116494

DOCUMENTS ATTACHED: Notes from Chris' file written by Dr. Frizzell and blood tests showing positive ANA results for Lupus.

MESSAGE: I will fax an additional letter from Dr. Frizzell with further explanation regarding Chris' current medical condition. Thank you for your time this morning. I hope the Appeal Committee will understand how ill my husband is at this point in time. Also, I would hope that they would take under consideration the statement made by Mr. Richmond regarding accommodation as a false and malicious statement. He and Rural Telephone never had any intention of accommodation. At present, it is also a moot point. Chris simply can not work, the Lupus has made him so ill that he must rest for most of each day. He also has so much back pain that he can not sit, he must lie down in bed or rest in his recliner. As I stated, this was a man who worked very hard, averaging 120 hours in a bi-monthly pay period. I am sure if one did a survey of the average hours worked by Controllers or CPA's that this is not out of the ordinary. He is very upset by the decline in his health, given a choice, of course, he would choose to work. He has no choice now.

* Including cover sheet.

IDAHO NEUROLOGICAL SURGERY, P.A.

DOUGLAS E. SMITH, M.D.
CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

R. TYLER FRIZZELL, M.D., PH. D.
CERTIFICATION ELIGIBLE AMERICAN BOARD OF NEUROLOGICAL SURGERY

April 22, 2002

Re: Chris Dennison

TO WHOM IT MAY CONCERN:

Mr. Dennison is under my care for failed back syndrome and a history of lupus. He has had multiple surgeries and intractable back, neck, and leg pain.

It is my opinion that Mr. Dennison is disabled from these conditions and not able to engage in work of any kind.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/egs

222 NORTH SECOND STREET, SUITE 307 • BOISE, IDAHO 83702 • (208) 344-1000

2/7/02 CHRIS DENNISON

Mr. Dennison returns to clinic for follow-up of his neck and back pain.

His MRI shows some degenerative disc disease at L4-5 and L5-S1 with a mild protrusion and some degenerative changes in the cervical area. There is no surgical lesion.

He still has disabling back pain and is not able to work. This appears permanent, since he has had maximum medical therapy including multiple surgeries.

PLAN: I would like to see him a couple times a year to make sure there is no new surgical problem. He will follow-up with Dr. MacCarter.

RTF/egs R. TYLER FRIZZELL, M.D.

cc: Daryl K. MacCarter, M.D.

ST. LUKE'S MERIDIAN MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
520 S. EAGLE RD, MERIDIAN, ID 83642

20P
DENNISON,CHRIS J
DOB: 10/09/1950 SEX: M
22698159 MR#: 542615

PHYSICIAN: 630
FRIZZELL,R. TYLER
222 N 2ND ST SUITE 307
BOISE,ID
83702

T31526 COLLECTED: 04/30/2002 09:01

CBC					**PL: M
WBC COUNT		4.6	[4.5-11.0]	K/UL	
RBC COUNT		4.98	[4.30-5.90]	MIL/UL	
HEMOGLOBIN		15.6	[13.9-16.3]	G/DL	
HEMATOCRIT		44.4	[39.0-55.0]	%	
MCV		89.0	[80.0-100.0]	FL	
MCH		31.3	[25.0-35.0]	PG	
MCHC		35.2	[31.0-37.0]	%	
RDW-CV		12.8	[11.0-16.0]	FL	
PLATELET COUNT		272	[130-350]	K/UL	
AUTO DIFFERENTIAL					**PL: M
NEUTROPHIL %		62	[40-76]	%	
LYMPHOCYTE %		24	[24-44]	%	
MONOCYTE %		9	[1.0-10.0]	%	
EOSINOPHIL %	*	4	[0.0-3.0]	%	
BASOPHIL %		1	[0.0-1.0]	%	
NEUTROPHIL #		2.9	[1.90-8.00]	K/UL	
LYMPHOCYTE #		1.1	[1.00-4.00]	K/UL	
MONOCYTE #		0.4	[0.10-0.80]	K/UL	
EOSINOPHIL #		0.2	[0.00-0.50]	K/UL	
BASOPHIL #		0.0	[0.00-0.10]	K/UL	
CK	*	313	[35-232]	U/L 37	**PL: M
HEPATIC FUNCTION PANEL					**PL: M
ALBUMIN		4.1	[3.4-5.0]	GM/DL	
AST(SGOT)		36	[10-40]	U/L 37	
TOTAL BILIRUBIN		0.3	[0-1.3]	MG/DL	
DIRECT BILIRUBIN		0.1	[0.0-0.4]	MG/DL	
TOTAL PROTEIN		7.0	[6.0-8.0]	GM/DL	
ALKALINE PHOSPHATASE		116	[50-136]	U/L 37	
ALT(SGPT)		65	[30-65]	U/L 37	

END OF REPORT

** PERFORMING LAB: M ST. LUKE'S REGIONAL MEDICAL CENTER
MR1 ST. LUKE'S MERIDIAN MEDICAL CENTER

DENNISON,CHRIS J
04/30/2002 16:11

ST. LUKE'S MERIDIAN MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
520 S. EAGLE RD, MERIDIAN, ID 83642

20P
DENNISON,CHRIS J
DOB: 10/09/1950 SEX: M
22659338 MR#: 542615

PHYSICIAN: 630
FRIZZELL,R. TYLER
222 N 2ND ST SUITE 307
BOISE,ID
83702

H14918 COLLECTED: 03/21/2002 15:07

ANA SCREEN			**PL: M
ANTI-NUCLEAR AB	*	POSITIVE Reference range: NEGATIVE Test performed at Quest Diagnostics Incorporated, San Juan Capistrano, California.	
ANA, TITER & PATTERN			**PL: M
ANTI-NUCLEAR AB TITER	*	80 Reference range: <40 Unit: Titer	
ANA PATTERN		HOMOGENEOUS Test performed at Quest Diagnostics Incorporated, San Juan Capistrano, California.	

A positive ANA result may be seen in a variety of diseases and healthy individuals. Its interpretation depends on clinical findings and other laboratory data.

END OF REPORT

** PERFORMING LAB: M ST. LUKE'S REGIONAL MEDICAL CENTER
MR1 ST. LUKE'S MERIDIAN MEDICAL CENTER

DENNISON,CHRIS J
03/26/2002 10:06

ST. LUKE'S MERIDIAN MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
520 S. EAGLE RD, MERIDIAN, ID 83642

20P
DENNISON,CHRIS J
DOB: 10/09/1950 SEX: M
22659338 MR#: 542615

PHYSICIAN: 630
FRIZZELL,R. TYLER
222 N 2ND ST SUITE 307
BOISE,ID
83702

H14918 COLLECTED: 03/21/2002 15:07

ESR	2	[0-20]	MM/HR	**PL: M

END OF REPORT

** PERFORMING LAB: M ST. LUKE'S REGIONAL MEDICAL CENTER
MR1 ST. LUKE'S MERIDIAN MEDICAL CENTER

DENNISON,CHRIS J
03/22/2002 04:38

FAX TRANSMISSION

CHRIS J. & KATHERINE W. DENNISON

9975 WEST HOLLANDALE DRIVE
BOISE, IDAHO 83709
(208) 658-0097
FAX (208) 658-0097(call in advance)
E-mail: katnchrisd@msn.com

	PAGES*	FAX NUMBER	TIME
TO: Nancy Deskins C.N.A. Appeals Committee	2	407-919-6574	

FROM: Katherine W. Dennison

DATE: June 10, 2002

RE: Chris J. Dennison, claim no.: 2395634, policy no.83116494

Documents: Letter via e-mail from Mike Richmond, Rural Telephone Co.

Message: Attached is an e-mail from Mike Richmond, Assistant General Manager for Rural Telephone Company. After repeated requests from me for a clarification of Chris' employment status, we received the attached e-mail. I remain at this point in total confusion as to Mr. Richmond' s March 12, 2002 statement to C.N.A regarding "reasonable accommodation". As I have pointed out, that statement by Richmond was malicious in nature and intended to harm Chris. Again, there was never an intention on his part or Rural Telephone's to accommodate anything. Further, they could not have accommodated him even if their intention was to help Chris. Perhaps now a true picture of the nature of this individual is clarified.

I must also add that until September 2001 his career (Richmond's) consisted of selling insurance. Chris and I have managed businesses for over 20 years and both have B.S. degrees in Business Administration from a very good business college. We both have had extensive training in business as well as human resources and understand the fiduciary duty that we have to our employers with regard to actions and statements we make on behalf of that employer. Obviously, M. Richmond needs to have a more clear understanding of his duties to his employer.

I faxed to you on May 31, 2002 a letter from Dr. Frizzell stating that Chris could not work. Would you please call me to confirm your receipt of that fax at 208-342-6066.

I will also add once again - my husband is a very ill man. If he were give a choice, he would work. He can not. I thank you in advance for your immediate response, time is of the essence.

* Including cover sheet.

KATHERINE\Fax Transmission\CHRIS J02.wpd

RURAL
TELEPHONE COMPANY

Dear Chris,

This letter follows your request for reconfirmation of your employment status. I will forward copies of my correspondence of March 8 and 29, 2002, to you, along with the original of this communication. As I advised you on March 8 and again on March 29, I understand that your employment terminated effective March 6, 2002, when you used up your accrued sick leave and vacation time.

Sincerely,

Michael T. Richmond
General Manager

FAX TRANSMISSION

CHRIS J. & KATHERINE W. DENNISON
9975 WEST HOLLANDALE DRIVE
BOISE, IDAHO 83709
(208) 658-0097
FAX (208) 658-0097(call in advance)
E-mail: katnchrisd@msn.com

PAGES*	FAX NUMBER	TIME
2	407-919-6574	

TO: Nancy Deskins
C.N.A. Appeals Committee

FROM: Katherine W. Dennison

DATE:
RE: Chris J. Dennison, claim no.: 2395634, policy no.83116494

Documents Attached: A letter from Dr. R. Tyler Frizzell dated

Message: Attached is a letter from Dr. Frizzell regarding my husband's health. I am handling the appeal process because of the gravity of his illness. I hope this assists in a positive and speedy result of the appeal. I also want to emphasis not only is my husband very ill but I have Multiple Sclerosis; I am the accounting manager for a very busy law firm, I am the sole care-giver for my husband. The additional stress created by the entire situation is having a negative affect on my health. Again, I thank you in advance for your immediate response, time is of the essence.

* Including cover sheet.
I:\KATHERINE\Fax Transmission\DOIS J.wpd

IDAHO NEUROLOGICAL SURGERY, P.A.

DOUGLAS E. SMITH, M.D.
CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

R. TYLER FRIZZELL, M.D., PH. D.
CERTIFICATION ELIGIBLE AMERICAN BOARD OF NEUROLOGICAL SURGERY

May 21, 2002

Re: Chris Dennison

TO WHOM IT MAY CONCERN:

Mr. Dennison has been under my care for low back and cervical neck surgeries. The patient is disabled from his spine condition and is not able to work. He is not able to work with accommodations. The patient also has rheumatological disease with positive lupus studies.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/cgs

222 NORTH SECOND STREET, SUITE 307 • BOISE, IDAHO 83702 • (208) 344-1000

CLAIM ANALYSIS RECORD

Claimant: Chris Dennison Claim Number: 2395634

3-14-02	Based on claimants limitations placed by physician, employers ability to accommodate the already sedentary occupation of controller to the limitations, and medical information on file, there is a lack of medical information to support a functional impairment from performing the occupation of controller. Will deny liability pending secondary review. BBarnum
3-14-02	Claim being sent for team leader or supervisory signoff. BBarnum
3-14-02	Claim reviewed. JMarchuck
3-15-02	Claim denied, letters sent to EE & ER. BBarnum
5-14-02	EE called to check & see if appeal received & I said no. Told EE that if he has copy of appeal to please fax. He said no problem. BBarnum
5-15-02	Rec'd file and copy of request for reconsideration. JKirk
5-15-02	Info rec'd does not contain additional medical that alters the original denial. In 2° review. JKirk
5-15-02	Reconsideration reviewed. JMarchuck
5-15-02	Letters sent. JKirk
5-16-02	Claim forwarded to Appeal. JKirk

CLAIM ANALYSIS RECORD

Claimant Chris Dennison Claim Number 2395634112

2/27/02	Rcvd claim for LTD processing / Early notice claim - file transferred to KC for continued processing - Aiken
2/28/02	File rec'd in KC. Assigned to Brian Barnum on this date. J. Marchick
3-7-02	Called ER + completed ER interview see enclosed. B Barnum
3-12-02	Called Mike Richmond at 208-366-2614 and asked about possible accomodations. He stated they will make any reasonable accomodations to accommodate his physical condition. Sit/Stand at will is not a problem. Mike stated all he knows is that Chris has suffered a back condition. B Barnum
03/14/02	NCM review of file. Given minimal findings per cervical/lumbar x-rays and MRI of entire spine, there is lack of medical information to support a functional impairment that would preclude the clmt from performing sedentary activities c̄ a sit/stand option — [signature] RN CCM

INSURANCE IN TOUCH WITH BUSINESS

P.O. Box 25939
Overland Park, KS 66225-5939

Tabatha Kirke
Disability Benefits Specialist
Telephone 1-800-303-9744 ext 5860
Fax 913-661-7777

May 15, 2002

Chris Dennison
9975 W Hollandale Drive
Boise, ID 83709

Claim No: 2395634
Policy No: 83116494
Underwritten by Continental Casualty Company
Services provided by CNA Group Life Assurance Company

Dear Mr. Dennison:

We have received your letter dated May 2, 2002 requesting that we reconsider our decision to deny future benefits on your claim. Along with your letter requesting reconsideration, we received a copy of a letter from your doctor and one from your employer to you regarding your final pay summary.

The letter we received from your doctor does not provide additional medical documentation that would change our decision of 3/15/02.

Because our decision to deny future benefits has not changed, your claim is being forwarded to the Appeals Committee. The Appeals Committee will advise you of their decision within 45 days of receipt of your recent letter. The Committee will notify you in writing if additional time will be required.

Sincerely,

Tabatha Kirke
Disability Specialist

Cc: James Martell
Rural & Pend Oreille Telephone Co.
704 W Madison Ave
Glenns Ferry, ID 83623

Kirke,Tabatha D.

From: Barnum,Brian K.
Sent: Wednesday, May 15, 2002 12:25 PM
To: Kirke,Tabatha D.
Subject: FW: Copies of original appeal letters, E-Mail 1 of 3

original leter of appeal. EE claims to have sent this information on 5/6/02 and someone signed for it. I never received anything & told him his appeal will be handled from the 5/14/02 receipt date. He verified that he sent 3 two page faxes yesterday and the beloe letter which consists of his entire appeal. Will bring file to you.

---Original Message---
From: Chris DENNISON [SMTP:katnchrisd@msn.com]
Sent: Tuesday, May 14, 2002 4:34 PM
To: brian.barnum@cna.com
Subject: Copies of original appeal letters, E-Mail 1 of 3

Brian,
The files would not E-Mail all at one time. the rest are to follow.
Thanks for your help.

CNAAppealLtr.doc

Chris

May 2,2002

Mr. Brian Barnum
Disability Benefits Specialist
C.N.A. Insurance
P.O. Box 25939
Overland Park, KS 66225-5939

"SENT VIA FEDERAL EXPRESS"

RE: Appeal of C.N.A. declination of long-term disability benefits, Claim #2395634, Policy #83116494.

Dear Mr. Barnum:

Attached is a letter from R. Tyler Frizzell MD regarding my physical condition and work limitations. Please reconsider my application for long-term disability benefits. Because of my physical limitations, I have not been able to work since February 1, 2002.

Additionally, there are two letters attached from Mr. Mike Richmond, dated March 8, 2002 and March 29, 2002, wherein he states that the Company considers my last day of employment with Rural Telephone Company March 6, 2002. In your letter dated March 15, 2002, you stated that on March 12, 2002 Mr. Richmond said they "will make any reasonable accommodations to accommodate his physical condition". I submit that this offer was without sincerity and contradictory, as evidenced by the date of Mr. Richmond's first letter dated March 8, 2002 and your telephone conversation with him on March 12, 2002. The Company effectively terminated my employment before your conversation with him.

If you have further questions or if there is anything I can do to accelerate the processing of this claim please call me at home, 208-658-0097. Time is of the essence because a delay will cause severe financial hardship. Thank you in advance for your consideration and assistance in this matter.

Best Regards,

Chris J. Dennison, CPA

PhoneTools

BVRP software

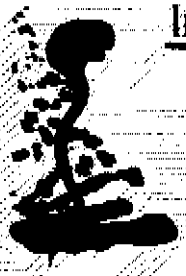
Phone: 208-658-0097
Fax: 208-658-0097

Message :

Form Attached

From:	To: CNA Insurance
Chris J Dennison, CPA	Mr Brian Barnum
Date: 5/14/2002	**Page(s):** 2

RECEIVED TIME MAY. 14. 4:37PM PRINT TIME MAY. 14. 4:40PM



IDAHO NEUROLOGICAL SURGERY, P.A.

DOUGLAS E. SMITH, M.D.
CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

R. TYLER FRIZZELL, M.D., PH. D.
CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

April 22, 2002

Re: Chris Dennison

TO WHOM IT MAY CONCERN:

Mr. Dennison is under my care for failed back syndrome and a history of lupus. He has had multiple surgeries and intractable back, neck, and leg pain.

It is my opinion that Mr. Dennison is disabled from these conditions and not able to engage in work of any kind.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/egs

222 NORTH SECOND STREET, SUITE 307 • BOISE, IDAHO 83702 • (208) 344-1000 • (800) 733-1989 • FAX (208) 344-1331

PhoneTools

BVRP software

Phone: 208-658-0097
Fax: 208-658-0097

Message :

Form Attached

From:	To: CNA Insurance
Chris J Dennison, CPA	Mr Brian Barnum
Date: 5/14/2002	**Page(s):** 2

RURAL TELEPHONE COMPANY
704 W. MADISON
GLENNS FERRY, IDAHO 83623
(208) 366-2614 • FAX (208) 366-2615

March 29, 2002

Chris J. Dennison
9975 W. Hollingdale Dr.
Boise, ID 83709

RE: Final Pay Summary

Dear Chris:

Below is a summarization of events and outline of your severance from Rural Telephone Company:

Accrued Sick Balance Depleted *(72 hrs)*:	February 13, 2002
Final 401k deduction/deposit:	February 27, 2002
Final payment to 401k loan *(from payroll deduction)*:	February 27, 2002
Earned/Used Vacation Balance Depleted *(120 hrs)*:	March 6, 2002
Separation Date:	March 6, 2002
Life Insurance discontinued:	March 6, 2002
NTCA Health Insurance valid through:	June 30, 2002*

As previously stated (March 8, 2002 letter), Rural Telephone Company will continue to pay your health insurance premiums through the second quarter, June 30,2002*. This date was shown as May 31, 2002 previously. We anticipate at this time, NTCA will be contacting you with COBRA information. In recognition of your service to the Company, Rural Telephone Company will pay the equivalent of 90-days regular pay to assist you during this time of transition from the workforce to a potential long-term disability status. Also, per your request, we have changed your exemptions to 9.

Enclosed you will find a check in the amount of $10,058.99; which represents the balance of your lump sum severance package.

It is important to note that the final payroll deduction for your 401k loan payment was made on February 27, 2002. We suggest you contact Copper Mountain Trust in regard to your options and/or obligations with respect to this loan.

Sincerely,

Michael T. Richmond
General Manager

Enclosure

PhoneTools

BVRP software

Phone: 208-658-0097
Fax: 208-658-0097

Message :

Form Attached

From:	To: CNA Insurance
Chris J Dennison, CPA	Mr Brian Barnum
Date: 5/14/2002	**Page(s):** 2

RURAL TELEPHONE COMPANY
704 W. MADISON
GLENNS FERRY, IDAHO 83623
(208) 366-2614 • FAX (208) 366-2615

March 8, 2002

Chris J. Dennison
9975 W. Hollingdale Dr.
Boise, ID 83709

RE: Separation Notice

Dear Chris:

As of March 8, 2002, your accrued sick leave and 2002 earned vacation time have been depleted and no additional hours are available. Therefore, Rural Telephone Company considers this as your final day of employment and will use March 8, 2002 as your separation/termination date from the Company.

As a courtesy, Rural Telephone Company will continue to pay your health insurance premiums through May 31, 2002. We anticipate at this time, NTCA will be contacting you with COBRA information. Your life insurance benefits are discontinued effective today and there will be no further 401k deductions/deposits.

Enclosed you will find a check in the amount of $1,052.15; which represents the balance of earned/used vacation time.

We are structuring a severance package and hope to meet with you sometime next week to discuss it.

Hope all is well with you. We look forward to visiting with you soon. If you have any questions in the meantime, please don't hesitate to contact me.

Sincerely,

Michael T. Richmond
General Manager

Enclosure

CNA INSURANCE IN TOUCH WITH BUSINESS

P.O. Box 25939
Overland Park, KS 66225-5939

Brian Barnum
Disability Benefits Specialist
Telephone 1-800-303-9744 KC ext. 5862
Fax 913-661-7777

March 15, 2002

James Martell
Rural & Pend Oreille Telephone Co
704 W. Madison Ave
Glenns Ferry, ID 83623

Re: Claimant: Chris Dennison
Policy No. 83116494
Claim No. 2395634
Underwritten by Continental Casualty Company
Services provided by CNA Group Life Assurance Company

Dear Mr. Martell:

This is to advise you of the status of Mr. Dennison's Long Term Disability claim.

Based on a thorough review of the information in his file, we have denied his claim for benefits.

We are unable to provide you with specific information in accordance with state privacy laws. However, a detailed explanation of our decision and his appeal rights have been sent to Mr. Dennison.

Should you have any questions regarding this claim please feel free to contact me.

Sincerely,

Brian Barnum ALHC, AIAA, ACS
Disability Specialist

INSURANCE IN TOUCH WITH BUSINESS

P.O. Box 25939
Overland Park, KS 66225-5939

Brian Barnum
Disability Benefits Specialist
Telephone 1-800-303-9744
Fax 913-661-7777

March 15, 2002

Chris Dennison
9975 W Hollandale Drive
Boise, ID 83709

Claim # 2395634
Policy # 83116494
Underwritten by Continental Casualty Company
Services provided by CNA Group Life Assurance Company

Dear Mr. Dennison:

This letter will acknowledge receipt of your claim for Long Term Disability benefits.

Please refer to your policy under the section entitled "Occupation Qualifier" which states:

> "Disability" means that during the elimination period and the following 24 months, injury or sickness causes physical or mental impairment to such a degree of severity that you are: 1. continuously unable to perform the material and substantial duties of your regular occupation; and 2. not working for wages in any occupation for which you are or become qualified by education, training or experience.

You are claiming disability due to back pain. A review of your claim was based on information contained in your file including medical information from Dr. Dallas Peck, Dr. Ralph Yeakley and Dr. R. Tyler Frizzell.

On the Physician's Statement completed by Dr. Frizzell under the section entitled "Physical Limitations" he states:

- No lifting, pushing or pulling over 5 pounds
- No prolonged standing or sitting
- Only occasional bending/twisting

On March 12, 2002 we contacted your employer who stated your occupation as a controller is strictly a sedentary job. Mike Richmond stated they "will make any reasonable accommodations to accommodate his physical condition." He also added that allowing a sit and stand at will option is not a problem.

To summarize, the only limitation given by Dr. Frizzell that would affect your occupation is no prolonged standing or sitting. As stated above, this limitation can be accommodated by your employer.

Therefore, based on information on file, there is a lack of medical information to support a functional impairment which would preclude you from performing the material and substantial duties of your occupation as a controller. Accordingly, we are unable to honor this claim for disability benefits.

If you disagree with our decision, you have the right to appeal under regulations specified by the Employee Retirement Income Security Act (ERISA) 1974 as amended.

If you have additional medical information not mentioned above or wish us to reconsider our decision, you should

- submit your formal request for reconsideration **in writing** to my attention **within 180 days** of the date of receipt of this letter

- addressed to **Attn: Brian Barnum**
  Commercial Claims
  P. O. Box 25939
  Overland Park, KS 66225

- Include your **claim number** and **policy number** on any correspondence.

Our decision will be reconsidered at the time of receipt of your information. If this information does not alter our decision, you will be informed of this and your claim will then be submitted for a formal appeal review. A ruling will be issued within 45 days of receipt of your request for reconsideration as mandated by the Employee Retirement Income Security Act (ERISA) 1974 as amended. This regulation allows an additional 45 days to reach a decision if necessary, however you will be notified within the first 45 days if this review will require an extension of time to reach a decision. This decision will be in writing and mailed directly to you or your representative. You have the right to bring a civil action under §502(a) of ERISA following an adverse decision on appeal.

Appeals received later than 180 days may not be considered.

Should you have any questions in connection with your claim, please feel free to contact us.

Sincerely,

Brian Barnum ALHC, AIAA, ACS
Disability Specialist

ER Interview for Chris Dennison

Called Susan Case and conducted ER interview for Chris Dennison on 3/7/02.

1. Verify the last day worked for Mr. Dennison? 2/7/02

2. Did Mr. Dennison miss any time prior to LDW for this injury? NO, not that I know of.

3. If so, what exact days did she miss?

4. Does Mr. Dennison have an estimated return to work date set? He told us, he does not have an anticipated RTW date.

5. Did Mr. Dennison have any work issues (ie, work history, upcoming events)? NO

6. What did Mr. Dennison's job consist of? Controller – Prepared all of our spreadsheets, took care of all the correspondance with the federal & state agencies, accounting supervisor who had 3-4 people under him. Perform all the financial audits. He had a 2 and ½ to three hour commute total each day. Straight desk job.

7. He mentioned he had to move boxes as part of his job. Was it part of the job? That is not necessarily part of his job, but we would have accommodated that if necessary.

8. Would you be able to accommodate a sit & stand option? I feel we would be able to, but Mike Richmond is the person to talk to there. He is out of the office right now, but I can have him call you in a couple of hours..

9. Verify Mr. Dennison's salary. $73,542.00 divided by 26 weeks.

B1:050 201002 2395634112

CNA

GROUP BENEFITS

FEB 15 2002

MAITLAND

LTD EMPLOYER'S STATEMENT

CNA Insurance Companies
1-800-303-9744

FEB 19 2002

For All the Commitments You Make®

Will do: 01/01/02

INSTRUCTIONS TO EMPLOYER: Complete the Employer's Statement & **attach job description.** Instruct employee to complete Employee's Statement and have Physician's Statement completed. Mail the forms so that they **ARRIVE** at least **30 days before the end of the elimination period.**

LTD

Name (Last, first, middle initial)	Telephone No. (Include Area Code)	Date of Birth
Dennison, Chris J	(208) 658-0097	10/09/50

Address (Street number, city, state, zip code)
9975 W Hollandale ~~XXX~~ Dr, Boise, ID 83709

Date Employed	Effective Date of LTD Coverage	SSN	Employee Class
07/01/97	08/01/99	552-64-7849	Salary, ~~Mgt~~

Percentage of Employer Contribution Toward Disability Premium: 100%	LTD Premium paid with	Is the employee's ~~LTD coverage~~ continuous since the original effective date?
	☒ Pre Tax ☐ Post Tax	☒ Yes ☐ No

How is the employee paid?	Pay Frequency:
☐ Hourly ☒ Salary ☐ Salary Plus Bonus ☐ Monthly ☐ Commissions Only ☐ Other:	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☒ Semi-Monthly

Basic Earnings as of last day worked: 6,129 mos	Number of regularly scheduled hours per week: 40	Effective date of reported salary or wage: 12/31/01	Occupation
			Controller

Duties: (include physical activities, hazards and skills required.) **Attach job activities statement or job description.**
accounting for 7 entities, supervise 4 to 7 employees, maintain general ledgers,on computer, create management reports, communicate with PUC's accountants, attorneys, consultamts, re: audits, rate cases, general busine

Date last worked prior to current disability 02/01/02	Has Employee worked part-time or partial duties since disability began? ☐ Yes ☒ No (If Yes, explain on reverse side)

Is disability due to injury or sickness arising out of employment? ☐ Yes ☒ No **(If Yes, send copy of Report of injury form.)**	Has employee retired? ☐ Yes ☒ No If Yes, Input Date: ___/___/___	Has employee terminated? ☐ Yes ☒ No

Workers' Compensation? ☐ Yes ☒ No	Amount of Benefits $ Per	Date Benefits Began	Date Benefits Paid Through

Name and Address of Workers' Compensation Carrier	W/C Claim #:
	Adjuster:
	Phone #:

Please indicate any benefits your employee has received or is entitled to receive during this disability. This would include but not be limited to company sponsored short-term benefits. State disability benefits, sick pay, salary continuance, commissions and / or bonuses.

☒ Sick Pay ☐ State Disability Income ☒ STD ☒ Other Sources (Explain): 3 weeks vacation
☐ Amount d Benefits: $_____ Per 8 days sick, 15 ~~X~~ days vacations @ $34.62 per hr

Date Benefit Began	Date Benefit Paid Through	If more than one source, please list on back.
02/04/02	90 Days	90 days includes sick & vacation

Employer / Policy Holder's Name	Policy Number	Telephone No. (Include Area Code)
company paid Rural & Pend Oreille Telephone Co	SR ~~83116551~~ 83116044	(208) 366-2614

Address (Street number, city, state, zip code)
704 W Madison Ave, Glenns Ferry, ID ~~83623~~

Completed By (Signature)	Title	Date
James R Maitland	PRESIDENT	2/11/02

GROUP LTD AND LIFE WAIVER OF PREMIUM CLAIM FORM

CNA

Claims Customer Service: 1-800-303-9744

Continental Casualty Company (Disability)
Continental Assurance Company (Life)

PART A– STATEMENT OF EMPLOYER

Instructions:

- Complete the Employer's Statement
- Include Enrollment Form(s)/Beneficiary Designation(s)
- Attach Job Description including any physical demands
- If Worker's Compensation - include Notice of Injury, Name of Carrier and Telephone Number
- If Accident - include copy of Accident Report
- If Contributory (Employee paid) - include Proof of Premium Deductions
- Instruct Employee to complete Employee's Statement and have Physician's Statement Completed
- Mail the forms so that they arrive at least 30 days before the end of the LTD elimination period

Name of Policy Holder/Employer (as it appears on your policy): & Pend Oreille Rural Telephone Companies

Policy Number(s) / Effective Dates(s)

LTD # SR-83116494 — 08/01/99

Life # _____

LTD: Employer Contribution 100 %

☒ Pre-Tax ☐ Post Tax

Employee Name Chris J Dennison

Social Security # 552-64-7849

Status ☐ Exempt ☐ Hourly ☐ Non-Exempt ☒ Salaried

Monthly Salary $ 6,129

Hourly Rate $ _____

Effective Date of Reported Salary 12/31/01

Date of Hire 07/01/97

Occupation Controller

☒ Full-Time ☐ Part-Time

No. of Hours Average btw 10-15 hours daily

Last actively at work date February 1, 2001

Return to work date N/A
(if applicable)

Termination Date N/A
(if applicable)

Amount of Life Insurance:

Basic $ _____

Supplemental (if applicable) $ _____

Voluntary (if applicable) $ _____

Total $ _____

Is Employee receiving any other weekly or monthly income? ☐ Yes ☒ No

Pension / Retirement – Date Started _____ Date Ended _____

Worker's Comp. Date Started _____ Date Ended _____

STD (Short Term Disability) Date Started 8days sick, 15 days vacation @$34.62 per hour Amount $ _____ Frequency _____ Date Ended _____

Paid Sick Leave Date Started February 4, 2001 plus 67 days for company paid s/t disb

8 days sick leave, 3 weeks vacation leave & company paid S/T ~~expires~~ until L/T starts.

Trustee or Employer Representative (Print or Type) James R Martell

Address 704 W Madison Ave, Glenns Ferry, ID 83623

Signature James R Martell Date 2/11/02

Phone (Ext.) 208-366-2614 Fax 208-366-2615 Email None

RURAL TELEPHONE COMPANY
Position Description

Employee: Chris J. Dennison	**Title:** Controller
Office Location: Glenns Ferry	**Department:** Finance/Operations
Reports to: James R. Martell	

The overall objective of my department is:

To optimize company performance by enhancing operational and financial workmanship.

My major function is:

To plan, direct, coordinate and control the financial & accounting department. Assist with all lines of business, including subsidiary activities, by interpreting and implementing the objectives of the President and Board of Directors. Assist the President with Company management.

In order of importance, the principal responsibilities:

1. To safeguard the Company's assets and fairly record Company liabilities by managing all accounting and financial operations, including: establishing operating procedures, Company policy, billing, receipts, disbursements, accounting and financial record keeping and reporting, budgeting and cash flow management, recommend and administer investments, and assist our outside accountants, attorneys and consultants in representing us to government regulatory agencies.

2. Assist in training managers and staff for greater productivity, accuracy and timeliness. To assist in scheduling and conducting annual staff performance reviews and recommend financial reviews when needed. To schedule, perform and submit my personal performance review annually, at my hire date anniversary.

3. Help determine new business and Company objectives. To daily administer internal operations.

4. To hold down expenditures and preserve the economic welfare of the Company. To preserve the confidential nature of the company's business and adhere to the highest ethical standards and loyalty when representing and dealing with the company, customers, other companies and other employees.

5. Meet with the management committee & Board of Directors as needed. To perform any other tasks and duties that may be permanently or temporarily assigned to me from time to time.

Agreed to: Chris J Dennison **Date:** 12/13/20

Approved by: **Date:**

INSURANCE IN TOUCH WITH BUSINESS

P. O. Box 25939, Overland Park, KS 66225-5939

2/19/02

Tabatha Kirke
Disability Specialist
Commercial Accounts Claims
Telephone 913-661-5860
Facsimile 913-661-7777

FAX COVER SHEET

RECIPIENT'S NAME: Susan

COMPANY: Rural and Pend Oreille Telephone Co.

FAX ACCESS NUMBER: 208-366-2615

NUMBER OF PAGES: several

CLAIMANT NAME: Chris Dennison

CLAIM NUMBER: 2395634

Here is the info you requested. We will turn this into an LTD claim as your STD coverage was terminated effective 1/1/02.

Give me a call if this is wrong or you have any questions.

Tabatha Kirke

45:050
201002

CNA

For All the Commitments You Make®

Short Term Disability Claim

EFF Date: 01/01/02

#23956341

INSTRUCTIONS: Complete Part I of this form per Short Term Disability guidelines. When forwarding the form to your employee, include a self-addressed envelope. If you have any questions regarding completion of this form, please contact the CNA Claim Processing Center at **1-800-303-9744.**

To be Completed by Employer

Employer's Name Rural Telephone Company			**Policy Number** SR-83116551	
Location Glenns Ferry, ID	**Class**	**Date of Hire** 07/01/97	**Effective Date of Coverage** 01/01/2000	**Employer Contribution:** 100% ☐ Pre-tax ☐ Post-tax
Employee's Name Chris J Dennison			**Occupation** Controller	
Employee's Address 9975 W Hollandale Dr, Boise, ID 83709				**Employee's Phone Number** 208-658-0097
Date of Birth 10/09/50	**Social Security Number** 552-64-7849	**Salary** $ 73,542 annually	**Hourly Wage/Hours Worked**	**Days Regularly Worked** ☐ S ☒ M ☒ T ☒ W ☒ T ☒ F ☐ S
Does job require lifting or carrying? ☒ Yes ☐ No		**If yes, indicate maximum amount of weight required to be lifted or carried:** 50 pounds		
Briefly describe employee's activities including major physical demands: accounting & billing supervisor, controller, computer, calculator				
Nature of Disability Back Pain				**Is This a Work Related Disability?** ☐ Yes ☒ No
Is employee receiving or entitled to receive other benefits? ☐ Yes ☒ No		**If yes, indicate the source and amount the employee is receiving:**		
Day Last Worked 11/29/01		**Date Employee Expected to Return to Work** ----------		**Sick Bank Paid Through** 36 hours left
Company Contact Name James R Martell			**Title** President	**Work Telephone Number** 208-366-2614
Contact's Signature				**Date**

To be Completed by Employee

Your attending physician should complete part III of this form.

Delay in submitting this form could interrupt continuation of your benefit payment.

I hereby authorize any physician, hospital, employer, insurer, or other organization or person having any records, dates or information concerning me to furnish such records as may be requested by CNA or their authorized representative.

EMPLOYEE SIGNATURE	**Date**

* * * COMMUNICATION RESULT REPORT (FEB. 19. 2002 3:03PM) * * *

TTI CNA GROUP BENEFITS

FILE MODE	OPTION	ADDRESS (GROUP)	RESULT	PAGE
3006 MEMORY TX		812083662615	OK	5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

CNA INSURANCE IN TOUCH WITH BUSINESS

P. O. Box 25939, Overland Park, KS 66225-5939

Tabatha Kirke
Disability Specialist
Commercial Accounts Claims
Telephone 913-661-5860
Facsimile 913-661-7777

2/19/02

FAX COVER SHEET

RECIPIENT'S NAME: Susan

COMPANY: Rural and Pend Oreille Telephone Co.

FAX ACCESS NUMBER: 208-366-2615

NUMBER OF PAGES: several

CLAIMANT NAME: Chris Dennison

CLAIM NUMBER: 2395634

8:050
201002

1 3 2002

CNA

Short Term Disability Claim

For All the Commitments You Make®

WPDate: 01/01/02

#2395634

INSTRUCTIONS: Complete Part I of this form per Short Term Disability guidelines. When forwarding the form to your employee, include a self-addressed envelope. If you have any questions regarding completion of this form, please contact the CNA Claim Processing Center at **1-800-303-9744.**

STD
QO

Part I To be Completed By Employer Only

Employer's Name Pend Oreille Rural Telephone Company			**Policy Number** SR-8334551	
Location Glenns Ferry, ID	**Class**	**Date of Hire** 07/01/97	**Effective Date of Coverage** 01/01/2000	**Employer Contribution:** 100% ☐ Pre-tax ☐ Post-tax
Employee's Name Chris J Dennison			**Occupation** Controller	
Employee's Address 9975 W Hollandale Dr, Boise, ID 83709				**Employee's Phone Number** 208-658-0097
Date of Birth 10/09/50	**Social Security Number** 552-64-7849	**Salary** $73,542 annually	**Hourly Wage/Hours Worked**	**Days Regularly Worked** ☐ S ☒ M ☒ T ☒ W ☒ T ☒ F ☐ S
Does job require lifting or carrying? ☒ Yes ☐ No		**If yes, indicate maximum amount of weight required to be lifted or carried:** 50 pounds		

Briefly describe employee's activities including major physical demands:
accounting & billing supervisor, controller, computer, calculator

Nature of Disability Back Pain	**Is This a Work Related Disability?** ☐ Yes ☒ No
Is employee receiving or entitled to receive other benefits? ☐ Yes ☒ No	**If yes, indicate the source and amount the employee is receiving:**

Day Last Worked 1/29/02	**Date Employee Expected to Return to Work** ----------	**Sick Bank Paid Through** 36 hours left
Company Contact Name James R Martell	**Title** President	**Work Telephone Number** 208-366-2614
Contact's Signature		**Date**

Part II Instructions to Employee

Your attending physician should complete part III of this form.

Delay in submitting this form could interrupt continuation of your benefit payment.

I hereby authorize any physician, hospital, employer, insurer, or other organization or person having any records, dates or information concerning me to furnish such records as may be requested by CNA or their authorized representative.

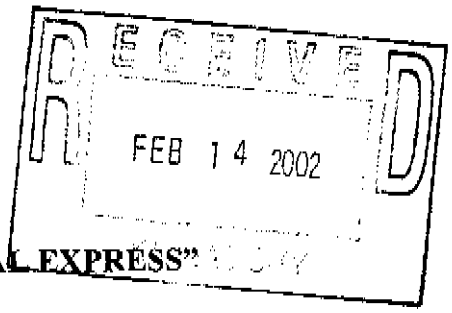
EMPLOYEE SIGNATURE	**Date**

Part III To Be Completed By Attending Physician Only

Complete Diagnosis with Complications (if surgery was performed, please describe):
failed back Sundroom
multiple Surgeries

Was Patient Hospitalized? ☐ Yes ☐ No Not Recent	**Date Admitted** N/A	**Date Discharged**
First Date of Treatment for Above Condition 2/24/98	**Date Total Disability Commenced** 2/7/02	**Last Date of Treatment** 2/7/02
Expected Return to Work Date N/A	**Can patient resume full duties upon return to work?** ☐ Yes ☒ No **If no, please explain:**	
Is Disability Due to: ☐ Sickness ☐ Injury ☐ Work Related ☐ Pregnancy LMP: _____		**Expected Date of Delivery** N/A
Physicians Name and Address R. Tyler Frizzell, M.D., Ph.D.		**Physician's Telephone Number** 208-344-1000
Attending Physician's Signature	**Date** 2/7/02	**Physician's FAX Number** 208 344-1331

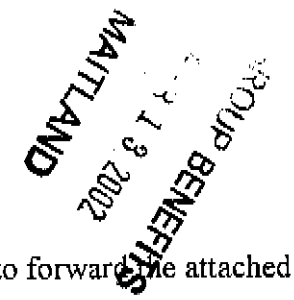
G-13201-C Online version **Please attach supporting documentation and/or test results** Revised 11/00



February 8, 2002

"SENT VIA FEDERAL EXPRESS"

Mr. Mark Crisler
CNA Group Benefits
1420 5th Avenue, Suite 2005
Seattle, Washington 98101



RE: Attached Long Term Disability Forms

Dear Mark:

Ms Trish Coba, from Seabury & Smith, instructed me to forward the attached forms to you. Included are the online versions of:

- Form LD-1001-A: Group LTD and Life Waiver of Premium Claim Form
- Form G-102063-A: Claimant's Job Activities Statement
- From G-116298-C: LTD Employer's Statement
- Form G-116299-B: LTD Employee's Statement
- Form G116300-C: Physician's Statement

I believe all of the forms are properly completed and signed, but since I have never prepared anything like this, I'll need your help. I appreciate any assistance that you may give. Trish requested that you call her when you receive the forms. Her telephone number is 208-338-6457.

You can reach me at either of the following numbers, home – 208-658-0097 and cell phone – 208-602-5791. I don't know if I can continue work with the present pain levels and medications, however, my work number is 208-366-2614.

Thanks in advance fro your help.

Best Regards,

Chris J. Dennison

Chris J. Dennison

INTERMOUNTAIN MEDICAL IMAGING

927 W. MYRTLE ST.
BOISE, IDAHO 83702
(208) 367-7510

www.idahoxray.com

G. W. BROWN, MD
C. H. COULAM, MD
I. C. DAVEY, MD
N. C. DAVEY, MD
V. GARABEDIAN, MD
R. J. GOBEL, MD
J. T. HALL, MD
J. Q. KNOCHEL, MD
W. T. MURRAY, MD
D. R. NEWTON, MD
D. D. PECK, MD
L. M. SCALES, MD
J. T. SEABOURN, MD
P. D. TRAUGHBER, MD

Patient:	DENNISON, CHRIS J	**Hosp. Serv.:**	DXT - ZZA	**Dict. MD:**	DALLAS PECK, MD
MR #:	374376	**Room/Bed:**		**Req. MD:**	R. TYLER FRIZZELL, MD
Visit #:	203504949	**P. Date:**	02/04/2002	**Req. MD:**	2/5 RR to pt Jan
Date of Birth:	10/09/1950	**Exam #:**	759757		

Job Number: 714719 **Version: 1** **Page 1 of 2** Has appt 2/7

SCREENING MAGNETIC RESONANCE IMAGING STUDY OF THE ENTIRE SPINE WITHOUT AND WITH INTRAVENOUS GADOLINIUM, 2/4/2002

HISTORY: Back pain and severe left lower extremity pain.

TECHNIQUE: Please refer to the MRI prescription sheet for details. Intravenous gadolinium (20 cc) was administered as a part of this examination.

FINDINGS:

The patient developed nausea and vomited just after the intravenous administration of gadolinium. No other symptoms of allergic type reaction.

CERVICAL SPINE: The overall alignment of the cervical spine is maintained. The vertebral bodies at C5-6 appear to be fused anteriorly. No evidence of disk herniation, overall spinal canal stenosis of neural foraminal narrowing is identified. There are changes of degenerative disk disease at C4-5 and C6-7 with mild diffuse posterior disk bulges at these levels. The cervical cord maintains normal size, signal and shape throughout. The craniocervical junction has normal appearance.

THORACIC SPINE: The normal alignment of the thoracic spine is maintained. Marrow signal is normal within the visualized bones. The thoracic cord is of normal size, signal and shape throughout. There are changes of mild degenerative disk disease within the mid thoracic spine which are most prominent at T6-7 with mild diffuse disk bulge at this level without evidence of overall spinal canal stenosis or neural foraminal narrowing.

LUMBAR SPINE: The overall alignment of the lumbar spine is maintained. The conus is at the level of T12-L1. The visualized cord is of normal size, shape and signal. There are reactive marrow changes adjacent to the end plates at L4-5 and L5-S1.

L1-2: There is relative disk desiccation and mild disk height loss without evidence of disk herniation, spinal canal stenosis or neural foraminal narrowing.

L2-3: There is a circumferential disk bulge superimposed tiny posterior right paracentral disk protrusion without evidence of overall spinal canal stenosis of neural foraminal narrowing.

L3-4: There is no evidence of disk herniation, spinal canal stenosis or neural foraminal narrowing at this level.

Patient:	DENNISON, CHRIS J	Hosp. Serv.:	DXT - ZZA	Dict. MD:	DALLAS PECK, MD
MR #:	374376	Room/Bed:		Req. MD:	R. TYLER FRIZZELL, MD
Visit #:	203504949	P. Date:	02/04/2002	Req. MD:	
Date of Birth:	10/09/1950	Exam #:	759757		

SCREENING MAGNETIC RESONANCE IMAGING STUDY OF THE ENTIRE SPINE WITHOUT AND WITH INTRAVENOUS GADOLINIUM, 2/4/2002

L4-5: There are postoperative changes from left hemilaminectomy and discectomy. A small amount of enhancing tissue is present within the left lateral recess compatible with scar or granulation tissue. No evidence of recurrent or residual disk herniation is identified. The neural foramina are widely patent bilaterally. There is no evidence of overall spinal canal stenosis at this level. There are moderate bilateral facet osteoarthritic changes.

L5-S1: There are changes of severe degenerative disk disease with disk desiccation and marked disk height loss. There is a small broad based posterior central disk protrusion which results in mild to moderate left lateral recess stenosis and possible mass effect on the traversing left S1 nerve root. There are postoperative changes from discectomy at this level in the past with small amount of scar or granulation tissue which enhances in the left lateral recess. No evidence of overall spinal canal stenosis or neural foraminal narrowing is identified at this level.

OPINION:

CHANGES OF MILD DEGENERATIVE DISK DISEASE WITHIN THE MID CERVICAL AND MID THORACIC SPINE AS DETAILED IN THE FULL REPORT, WITHOUT EVIDENCE OF DISK HERNIATION, SPINAL CANAL STENOSIS OR NEURAL FORAMINAL NARROWING. THERE ARE POSTOPERATIVE CHANGES FROM LEFT-SIDED HEMILAMINECTOMY AND DISCECTOMIES AT L4-5 AND L5-S1. AT L5-S1 THERE IS A SMALL BROAD BASED POSTERIOR CENTRAL DISK PROTRUSION WHICH RESULTS IN MILD TO MODERATE LEFT LATERAL RECESS STENOSIS. MORE MILD CHANGES OF DEGENERATIVE DISK DISEASE ARE PRESENT THROUGHOUT THE REMAINDER OF THE LUMBAR SPINE.

DP : ar
D/D: 02/05/2002 07:02
T/D: 02/05/2002 11:57
J#: 714719
T#: 14069929

DALLAS PECK, MD

CC:
R. TYLER FRIZZELL, MD

BOISE RADIOLOGY GROUP, PA
TODD B. BURT, MD
CHARLES R. CARRASCO, MD
ELAINE N. DANIEL, MD
RICHARD H. LANE, MD
PETER A. LANGHUS, MD
CRAIG E. LEYMASTER, MD
STEVEN V. MARX, MD
JAMES A. MAXWELL, MD
BRENT D. NELSON, MD
RAY M. THORPE, MD

St Luke's
Regional Medical Center
Department of Medical Imaging
190 East Bannock Street
Boise, Idaho 83712
Phone (208) 381-2415

DEPARTMENT OF MEDICAL IMAGING
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MAGNETIC RESONANCE IMAGING
NUCLEAR MEDICINE
PEDIATRIC IMAGING

BAX - ANDERSON PLAZA DIAGNOSTIC X-RAY

RALPH M. YEAKLEY, M.D.

NAME: Dennison, Chris J
DOB: 10/09/1950
ADM: 01/29/2002 **DIS:** 01/29/2002

BILLING NUMBER: 000022605549
MEDICAL RECORD NO.: 0542615
ROOM: - **PT/SVC:** O/AMI

DATE:01/29/2002

TWO VIEW LATERAL LUMBAR SPINE

CLINICAL DATA: Leg numbness. Tailbone pain.

COMPARISON EXAM: None.

FINDINGS: The dictation is based on the assumption that there are five lumbar-type vertebrae. Moderate L4-S1 disk degeneration with marginal hypertrophic spurring and loss of disk space height is present. There is milder T11-T12 and L1-L2 disk degeneration with some mild hypertrophic spurring. No spondylolysis or spondylolisthesis.

CONCLUSION: Mild thoracolumbar and moderate L4-S1 degenerative disk disease.

ELECTRONICALLY AUTHENTICATED
RALPH M. YEAKLEY, M.D. Jan 31 2002 7:15A
Boise Radiology Group

T: LDM
d: Jan 30 2002 5:08P t: Jan 30 2002 10:51P
Document #881528 Job # 22970

CC: R. TYLER FRIZZELL

BOISE RADIOLOGY GROUP, PA
TODD B. BURT, MD
CHARLES R. CARRASCO, MD
ELAINE N. DANIEL, MD
RICHARD H. LANE, MD
PETER A. LANGHUS, MD
CRAIG E. LEYMASTER, MD
STEVEN V. MARX, MD
JAMES R. MAXWELL, MD
BRENT D. NELSON, MD
RAY M. THORPE, MD

St Luke's
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190 East Bannock Street
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DIGITAL ANGIOGRAPHY
INTERVENTIONAL RADIOLOGY
MAGNETIC RESONANCE IMAGING
NUCLEAR MEDICINE
PEDIATRIC IMAGING

BAX - ANDERSON PLAZA DIAGNOSTIC X-RAY

TODD B BURT, M.D.

NAME: Dennison, Chris J
DOB: 10/09/1950
ADM: 01/29/2002 **DIS:** 01/29/2002

BILLING NUMBER: 000022605549
MEDICAL RECORD NO.: 0542615
ROOM: - **PT/SVC:** O/AMI

DATE:01/29/2002

TWO VIEW LATERAL CERVICAL SPINE

CLINICAL DATA: Prior neck surgery. Arm numbness and neck pain.

COMPARISON EXAM: None.

FINDINGS: Surgical changes of prior C5-C6 interbody fusion is present and appears to be solid. There is mild to moderate C4-C5 and moderate C6-C7 disk space narrowing with associated marginal hypertrophic spurring and disk space loss. The spine is in normal alignment. No fracture or subluxation. The prevertebral soft tissues are unremarkable.

CONCLUSION: 1) There is a solid-appearing C5-C6 fusion. 2) Mild to moderate C4-C5 and moderate C5-C6 disk degeneration.

ELECTRONICALLY AUTHENTICATED
TODD B BURT, M.D. Jan 31 2002 9:26A
Boise Radiology Group

T: LDM
d: Jan 30 2002 5:07P t: Jan 30 2002 10:53P
Document #881522 Job # 22976

CC: R. TYLER FRIZZELL

GROUP LTD AND LIFE WAIVER OF PREMIUM CLAIM FORM

CNA

PART B – STATEMENT OF EMPLOYEE

Claims Customer Service: 1-800-303-9744

COMPLETE ALL INFORMATION & SIGN

Last Name	First Name	Middle	Date of Birth	S.S.#
Dennison	Chris	James	10/09/50	552-64-7849

Present Address (Street number, city, state, zip code): 9975 W Hollandale Dr, Boise, ID 83709 — Email: katnchrisd@msn.com

Telephone: 208-658-0097 — Fax: Same, call first — Employer Name: Rural Telephone Company

Occupation/Job Title: Controller — ☒ Full-Time ☐ Part-Time

Date when you last reported for work 02/01/02. Date you returned or expect to return to work N/A.

Date of First Medical Treatment for this condition 01/29/02

Are you now engaged in the duties of any occupation or endeavor for wages, profit or compensation?
☐ Yes ☒ No Explain:

Was an accident involved? ☐ Yes ☒ No If yes, how did the accident occur?

Were you at work when it happened? ☐ Yes ☐ No
If motor vehicle accident attach copy of the Police Accident Report.

Are you receiving or have you applied for any benefits, earnings or income other than those provided by your Employer?
☐ Yes ☒ No If yes, please provide the name(s), address, phone number(s) of all companies providing disability benefits:

Date Benefits began _____ Dated ended _____

Marital Status ☐ Single ☒ Married ☐ Divorced ☐ Widowed — List names and birth dates of spouse and all dependent children

Katherine W Dennison

****AUTHORIZATION****

Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company or an agent, attorney, consumer reporting agency or independent administrator, acting on his behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employment related information. I also hereby authorize the Social Security Administration to send a copy of the Award (including family awards, if any) or Disallowance Notice to CNA Group Benefits, PO Box 946710, Maitland, Florida 32794-6710 for Social Security Number: 552-64-7849 This information is required by Continental Assurance Company/Continental Casualty Company to calculate my disability benefits under Claim Number **(to be completed by CNA)**: _____. I understand that such information will be used by Continental Assurance Company /Continental Casualty Company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim. I agree that a photographic copy of this authorization shall be as valid as the original. I know it is a crime to complete this form with information I know is false or to omit any facts I know are important.

Signature Chris J Dennison **Date** 02/07/02

**** IMPORTANT NOTICE****

Residents of all states EXCEPT FL, NJ, AZ: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FLORIDA RESIDENTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NJ RESIDENTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ARIZONA RESIDENTS: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

I have read and I understand the above notice.

Signature Chris J Dennison **Date** 02/07/02

Enclose a copy of the accident or police report, Worker's Comp. Contact, if applicable.

← FILL OUT TOP PORTION OF PHYSICIAN'S STATEMENT ON PAGE 3

CNA

For All the Commitments You Make®

CNA Insurance Companies
1-800-303-9744

LTD EMPLOYEE'S STATEMENT

Company Name
Rural Telephone Company

✳ SEE ATTACHED SUPPLEMENTAL STATEMENT

Name (Last, first, middle initial)	Telephone No. (Include Area Code)	Date of Birth
Dennison, Chris J.	208-658-0097	10/09/50
Home Address (Street number, city, state, zip code)		**Social Security Number**
9975 W Hollandale Dr, Boise, ID 83709		552-64-7849
Mailing Address, if different from Home Address (Street number, city, state, zip code)		
9975 W. Hollandale Dr, Boise, ID 83709		

Marital Status:	If married, Spouse's Name & Birth Date	Number of Dependent	Birth Date of Youngest
☐Single ☒Married ☐Divorced ☐Widowed	Katherine 07/07/49	Children: 0	Dependent:

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date	Paid Thru Date
a. Social Security	☐	☒	☐	☐					
b. Workers' Compensation	☐	☒	☐	☐					
c. State Disability Insurance	☐	☒	☐	☐					
d. Retirement or Pension	☐	☒	☐	☐					
e. Other	☐	☒	☐	☐					

***Please Attach copies of letters or notices related to these Other Benefits**

If due to injury, how and when did this accident occur?		Date first treated for this sickness or injury:
N/A		01/29/02
How does sickness/injury prevent you from returning to work?	**Date last worked prior to current sickness/injury:**	**On what date were you able to or do you expect to return to work?**
✳ Pain while performing duties in ba		

List primary physicians you consulted because of this disability. (Use other side if necessary)

Physician's Name	Address	Phone No. (Incl. Area Code)	Dates Treated
1. R Tyler Frizzell M.D.Ph.D	1. 222 N. 2nd St. #307, Boise		1. 01/29/02
2.	2. Idaho, 83702, 208-344-1000		2. 02/07/02
3.	3.		3.
4.	4.		4.
5.	5.		5.

List all hospital confinements for this disability. (Use other side if necessary)

Name of Hospital	Address	Date Confined

Important: The following authorization must also be completed by the Employee:

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Continental Casualty Co. or an agent, attorney, consumer reporting agency or independent administrator acting on its behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide Continental Casualty Co. with financial or employment-related information. I also hereby authorize the Social Security Administration to send a copy of the Award (including family awards, if any) or Disallowance Notice to CNA Insurance for Social Security Number: 552-64-7849. This information is required by Continental Casualty Co. to calculate my disability benefits under Claim Number: _____. I understand that such information will be used by Continental Casualty Co. for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim. I agree that a photographic copy of this authorization shall be as valid as the original. I know it is a crime to complete this form with information I know is false or to omit any facts I know are important.

CHRIS J. DENNISON	Chris J Dennison	02/08/02
Name (Please Print)	Signature	Date Signed

Chris J. Dennison, 552-64-7849
Rural and Pend Oreille Telephone Companies Policy SR-83116494
Form G-116299-B-Online Version, LTD Employee's Statement
February 5, 2002

From April 1998 through April 1999 I underwent 5 back surgeries to alleviate continuous extreme pain in both my neck and lower back. At that time through April 2001 I believed that the problems were cured.

Beginning in April 2001 through today the pain has progressed in frequency, duration and intensity. I attempted to get by with over-the-counter pain medications. During this time and up to January 29, 2001 I was working between 60 to 80 hours a week. Two weeks ago the pain became so intense I returned to see R. Tyler Frizzell M.D. Ph.D., on January 29, 2001, about the problem. He requested both an X-ray and an M.R.I. and prescribed pain medication. I could not carry on with my job duties with the amount of pain I was experiencing. I could not, and still can't, stand or sit-up for longer than 10 to 15 minutes without shaking from the pain. My arms and legs become numb and lose feeling. When I attempt to stand up from sitting I initially lose my balance. I have no feeling in my fingertips and toes. The pain from my neck causes migraine headaches, causing an additional impediment to performing my job duties. I couldn't, and still can't, function while performing my job obligations because of the pain.

My last day of work was February 1, 2001. I don't believe I can continue within the scope of my job responsibilities or any duties until the pain subsides. My understanding is that medication will help but not cure the problem. My type of work requires a lucid mind that cannot exist while under the influence of drugs. I can't lift, I can't sit, I can't stand and I can't think well when taking the required medications or with a migraine headache.

Dr. Frizzell indicated, from the tests, three different places in my spine and neck that are causing the pain. We discussed treatment and a prognosis. From the discussion, long-term disability appears to be the only way to allow me the ability to alleviate the deterioration in my spine and some of the related pain. If I continue with my present job requirements the problem will only get worse.

My wife has Multiple Sclerosis and is progressively unable to maintain our household. I am not able to help her or "take-up-the-slack" because of pain and related lack of energy.

I approach long-term disability with trepidation because I enjoy my career and do not wish to stop working. Saying that, I can no longer live with the pain or the collateral incapacities.

CNA
For All the Commitments You Make®

CLAIMANT'S JOB ACTIVITIES STATEMENT

DATE: February 7, 2002

NAME: Chris James Dennison

CLAIM NO.:

JOB TITLE: Controller

DATE LAST WORKED: February 1, 2001

EMPLOYER/COMPANY NAME	ADDRESS	TELEPHONE NUMBER
Rural Telephone Company	704 W. Madison Ave. Glenns Ferry, ID 83623	208-366-2614

DIRECTIONS: PLEASE ANSWER THE FOLLOWING BASED ON YOUR USUAL JOB ACTIVITIES IMMEDIATELY PRIOR TO YOUR DISABILITY. IF THE ACTIVITY DOES NOT APPLY TO YOUR JOB PLEASE MARK "N/A".

1. Brief summary of your usual occupational duties prior to disability. Responsible for accounting records for seven entities. Manage 2 departments, finance & billing, supervising 5 employees. Accounting records are computerized & requires sitting for 10 to 18 hours,6 days a week, 50 at work & 40 to 50 hours at home. Handle Public Utilities issues for 3 states, including reporting, complaints & rate case preparation. Please see attached job description

2.

AVERAGE NO. OF HOURS WORKED	
PER DAY	PER WEEK
15	90

I WORK INSIDE 100 % OUTSIDE ____ % WITH PEOPLE 50 % ALONE 50 %

I SUPERVISE Yes xx No [ ] NUMBER OF PEOPLE 5-7 % OF TIME 100

3. Please circle the number of hours per day your Job requires the following:

SITTING	0	1	2	3	4	5	6	7	8	10-12 hours
STANDING	0	1	2	3	4	5	6	7	8	1- 2 hours
WALKING	0	1	2	3	4	5	6	7	8	1- 2 hours
DRIVING ,commuting	0	1	2	3	4	5	6	7	8	2.5 to 3 hours
~~OTHER~~ XXXXX	0	1	2	3	4	5	6	7	8	

PLEASE SPECIFY OTHER: _____

4. Does your Job require lifting or carrying? Yes XXX No _____. If yes, please complete the following:

	occasional # of Times/Day	Distance Carried 5-25 feet	Circle # of hours/day
0 – 5 lbs.			0 1 2 3 4 5 6 7 8
5 – 10 lbs.			0 1 2 3 4 5 6 7 8
10 – 25 lbs.			0 1 2 3 4 5 6 7 8

Types of Materials boxes containing papers and records 20 to 50 pounds

5. Does your Job require:

	YES	NO					
Language Skills	[X]	[ ]	Simple		Complex	English	Hours Per Day 10-18
Arithmetic Skills	[X]	[ ]	Simple		Complex	Accounting	Hours Per Day 10-18
Telephone Skills	[X]	[ ]	Simple		Complex	Yes	Hours Per Day 8-10
Public Speaking	[ ]	[X]	Simple		Complex		Hours Per Day
Hearing	[X]	[ ]	Simple		Complex	Yes	Hours Per Day 8-10

Please list types of Office Equipment your Job requires:

Computers, printers, calculator, telephones,

6. Are You: RIGHT HANDED [X] OR LEFT HANDED [ ]

Does Your Job Require

	YES	NO	RIGHT HAND	LEFT HAND
Simple Grasping	[X]	[ ]	[X]	[ ]
Pushing/Pulling	[ ]	[X]	[ ]	[ ]
Fine Manipulator	[X]	[ ]	[X]	[ ]

7. Previous Education, Training and Experience:

EDUCATION:

B.S. in Business Administration, Accounting Emphasis

TRAINING:

Certified Public Accountant, also Law Enforcement

EXPERIENCE:

10 years retail tire business, 22 years law enforcement, 17 years accounting & business management.

8. Additional comments to clarify or amplify all the above...

I CERTIFY THAT THE ABOVE STATEMENTS ARE COMPLETE RELATIVE TO THE OCCUPATION FOR WHICH I AM CLAIMING DISABILITY BENEFITS.

Signature: Chris J Dennison Date: February 7, 2001

RURAL TELEPHONE COMPANY
Position Description

Employee: Chris J. Dennison	**Title:** Controller
Office Location: Glenns Ferry	**Department:** Finance/Operations
Reports to: James R. Martell	

The overall objective of my department is:

To optimize company performance by enhancing operational and financial workmanship.

My major function is:

To plan, direct, coordinate and control the financial & accounting department. Assist with all lines of business, including subsidiary activities, by interpreting and implementing the objectives of the President and Board of Directors. Assist the President with Company management.

In order of importance, the principal responsibilities:

1. To safeguard the Company's assets and fairly record Company liabilities by managing all accounting and financial operations, including: establishing operating procedures, Company policy, billing, receipts, disbursements, accounting and financial record keeping and reporting, budgeting and cash flow management, recommend and administer investments, and assist our outside accountants, attorneys and consultants in representing us to government regulatory agencies.

2. Assist in training managers and staff for greater productivity, accuracy and timeliness. To assist in scheduling and conducting annual staff performance reviews and recommend financial reviews when needed. To schedule, perform and submit my personal performance review annually, at my hire date anniversary.

3. Help determine new business and Company objectives. To daily administer internal operations.

4. To hold down expenditures and preserve the economic welfare of the Company. To preserve the confidential nature of the company's business and adhere to the highest ethical standards and loyalty when representing and dealing with the company, customers, other companies and other employees.

5. Meet with the management committee & Board of Directors as needed. To perform any other tasks and duties that may be permanently or temporarily assigned to me from time to time.

Agreed to: Chris J Dennison **Date:** 12/13/00

Approved by: **Date:**

a Control number: 63

OMB No. 1545-0008

Safe, accurate, FAST! Use IRS e-file

Visit the IRS Web Site at www.irs.gov.

b Employer identification number: 930739703

c Employer's name, address, and ZIP code:

RURAL TELEPHONE COMPANY
704 W. MADISON AVE.
GLENNS FERRY ID 83623

d Employee's social security number: 552647849

e Employee's name, address, and ZIP code:

Chris J. Dennison

9975 W. Hollingdale Dr.

Boise ID 83709

1 Wages, tips, other compensation: 68058.00	2 Federal income tax withheld: 11321.90
3 Social security wages: 72342.00	4 Social security tax withheld: 4485.20
5 Medicare wages and tips: 73542.00	6 Medicare tax withheld: 1066.42
7 Social security tips:	8 Allocated tips:
9 Advance EIC payment:	10 Dependent care benefits:
11 Nonqualified plans:	12a See instructions for box 12: Code D 4284.00
13 Statutory employee ☐ Retirement plan ☒ Third-party sick pay ☐	12b Code:
14 Other:	12c Code:
	12d Code:

15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name
ID	000186466	68058.00	4393.00			

Form **W-2** Wage and Tax Statement

2001

Department of the Treasury—Internal Revenue Service

Copy B To Be Filed with Employee's FEDERAL Tax Return.
This information is being furnished to the Internal Revenue Service.

FORM LW2B

CNA Insurance Companies
1-800-303-9744

PHYSICIAN'S STATEMENT

For All the Commitments You Make®

PLEASE PRINT – Use a separate sheet of paper to answer questions where space does not permit.

Patient's Name	Date of Birth
Chris J Bennison	10/09/50
Patient's Address – Street, City, State, Zip Code	**Phone Number (Area Code First)**
9975 W Hollandale Dr. Boise, ID 83709	208-658-0097
Employer's Name	**Policy Number**
Rural Telephone Company	SR-83116494

I hereby authorize release of information on this form, by the physician name on the reverse side of this form for the purpose of claim processing. Signature: Chris J Bennison **Date:** 02/07/02

1. HISTORY

(a) When did symptoms first appear or accident happen? Progressively from 04/01 to date — Month _____ Day _____ Year _____

(b) Date of first visit: Month 01 Day 29 Year 02

(c) Date you first advised patient to cease work: Month _____ Day _____ Year _____

(d) Has patient ever had same or similar condition? ☐ Yes ☐ No
If yes, please state when and describe:

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

2. MEDICAL CONDITION

(a) Diagnosis: Lumbago & Status post Lumbar/Cervical Surgeries

(b) Complications: Constant neck & back pain from multiple past surgeries

(c) Symptoms: Significant Deg. changes in Lumbar spine & narrowing

(d) OBJECTIVE FINDINGS (Please attach reports including x-rays, EKG's, Lab Data and any clinical findings):
+ Screening Spine MRI 2/4/02

3. NATURE OF TREATMENT

(a) What are the treatment plans? Meds, Conservative treatment

(b) Surgery: No further surgery

(c) Medications: Vicodin

(d) Has this person been referred to another physician? ☐ Yes ☑ No
Name and address of this physician:

(e) Date of last visit: Month 2 Day 7 Year 02

(f) Is further treatment required? Continued Periodic follow ups

4. PHYSICAL LIMITATIONS
What are the specific limitations (i.e., lifting, standing, stooping)

No lifting, pushing or pulling over 5#
No prolonged standing or sitting
Only occasional bending / twisting

5. Does this person have mental or nervous limitations? ☐ Yes ☑ No
If yes, please describe:

5. PROGNOSIS (Recovery and return to work date)

Poor
Condition is chronic & has re-gressed over time
Chronic pain in Lumbar & Cervical Spine

REMARKS:

Because of pts. multiple spine surgeries developed degenertive changes as well
Can only offer conservative treatment for pain management — no further surgery @ this time —

Name (Physician) Please Print	Specialty	Telephone
R Tyler Frizzell M.D.Ph.D.	Neuro-Surgery	208) 344-1000
Address – Street, City or Town, State or Province, Zip Code: 222 North Second Street, Suite 307, Boise, ID 83702		
Signature: R Tyler Frizzell		Date: 2/7/07

For information regarding where to mail this form, contact your Human Resource Representative, Benefits Administrator, or CNA Group Benefits Sales Representative.

GROUP LTD AND LIFE WAIVER OF PREMIUM CLAIM FORM

CNA

PART C – ATTENDING PHYSICIAN'S STATEMENT

EMPLOYEE: COMPLETE TOP PORTION AND SIGN BEFORE SENDING TO PHYSICIAN.

Patient's Name:	Date of Birth
Chris J Dennison	10/09/50
Patient's Address – Street, City, State, Zip Code	**Phone Number (Area Code First)**
9975 W Hollandale Dr, Boise, ID 83709	208-XXX 658-0097
Employer's Name	**Policy Number**
Rural Telephone Company	SR83116494, SR-83116551

I hereby authorize my Physician to provide the information below for the purpose of claim processing. I understand that I am responsible for any expenses related to the completion of this form.

Signature Chris J Dennison **Date** 02/07/02

PHYSICIAN: PLEASE COMPLETE THE INFORMATION BELOW AND ATTACH SUPPORTIVE MEDICAL DOCUMENTATION.

Complete Diagnosis. If surgery performed, please describe:
5/10 herniated Disc (Lumbar)
Now failed back Syndrome

Diagnostic Code:	Date(s) of Hospitalization:
724.2	4/1/98, 4/12/98, 3/3/99

Has the patient previously had the same or similar condition? ☑ Yes ☐ No If yes, When? Since 2/24/98
Please describe:

Is condition due to an Accident? ☐ Yes ☑ No If yes, is it work related? ☐ Yes ☐ No	Date of first treatment for this condition
	2/24/98

Date you advised patient to stop work due to this condition 2/7/02

Date you advised patient to return to work in any capacity NO

Comments:

Name and address of other treating physicians, if known: None related to back

Medical Findings (Attach office notes, results of physical examination, radiology, EKG, laboratory reports, etc.)
+ Screening Spine MRI

Treatment/Goals Conservative pain management
Chronic condition s Past Multiple Spine Surgeries

Name of Physician (Print)	Specialty
R. Tyler Frizzell, M.D., Ph.D.	Neuro - Surgery

Street Address:	City/Town:	State/Zip Code
222 North Second St, Suite 307	Boise	ID 83709

Telephone:	Fax	Email
208-344-1000	208 344-1331	

Signature: [signature] Date: 2/7/02

PLEASE RETURN THIS COMPLETED FORM TO YOUR PATIENT

CNA

For All the Commitments You Make®

Short Term Disability Claim

INSTRUCTIONS: Complete Part I of this form per Short Term Disability guidelines. When forwarding the form to your employee, include a self-addressed envelope. If you have any questions regarding completion of this form, please contact the CNA Claim Processing Center at **1-800-303-9744.**

I. To be Completed By Employer Only

Employer's Name			Policy Number	
Rural Telephone Company			SR-83116551	
Location	**Class**	**Date of Hire**	**Effective Date of Coverage**	**Employer Contribution:**
Glenns Ferry, ID		07/01/97	01/01/2000	100% ☐ Pre-tax ☐ Post-tax
Employee's Name			**Occupation**	
Chris J Dennison			Controller	
Employee's Address				**Employee's Phone Number**
9975 W Hollandale Dr, Boise, ID 83709				208-658-0097
Date of Birth	**Social Security Number**	**Salary**	**Hourly Wage/Hours Worked**	**Days Regularly Worked**
10/09/50	552-64-7849	$73,542 annually		☐ S ☒ M ☒ T ☒ W ☒ T ☒ F ☐ S
Does job require lifting or carrying?		**If yes, indicate maximum amount of weight required to be lifted or carried:**		
☒ Yes ☐ No		50 pounds		

Briefly describe employee's activities including major physical demands:
accounting & billing supervisor, controller, computer, calculator

Nature of Disability	Is This a Work Related Disability?
Back Pain	☐ Yes ☒ No

Is employee receiving or entitled to receive other benefits? ☐ Yes ☒ No	If yes, indicate the source and amount the employee is receiving:

Day Last Worked	Date Employee Expected to Return to Work	Sick Bank Paid Through
	----------	36 hours left

Company Contact Name	Title	Work Telephone Number
James R Martell	President	208-366-2614
Contact's Signature		**Date**

II. Instructions to Employee

Your attending physician should complete part III of this form.

Delay in submitting this form could interrupt continuation of your benefit payment.

I hereby authorize any physician, hospital, employer, insurer, or other organization or person having any records, dates or information concerning me to furnish such records as may be requested by CNA or their authorized representative.

EMPLOYEE SIGNATURE	Date

III. To Be Completed By Attending Physician Only

Complete Diagnosis with Complications (if surgery was performed, please describe):
failed back Syndrome
multiple Surgeries

Was Patient Hospitalized? ☐ Yes ☐ No	Date Admitted	Date Discharged
NOT Recent	N/A	
First Date of Treatment for Above Condition	**Date Total Disability Commenced**	**Last Date of Treatment**
2/24/98	2/7/02	2/7/02
Expected Return to Work Date	**Can patient resume full duties upon return to work? ☐ Yes ☒ No If no, please explain:**	
N/A		

Is Disability Due to:	Expected Date of Delivery
☐ Sickness ☐ Injury ☐ Work Related ☐ Pregnancy LMP: _____	N/A
Physicians Name and Address	**Physician's Telephone Number**
R. Tyler Frizzell, M.D., Ph.D.	208-344-1000
Attending Physician's Signature	**Date** / **Physician's FAX Number**
[signature]	2/7/02 / 208 344-1331


EXHIBIT
tabbies
B

Continental Casualty Company

CNA
For All the Commitments You Make®

CNA Plaza
Chicago, Illinois 60685

A Stock Company

EMPLOYER:	**Rural & Pend Oreille Telephone Companies** **104 West Madison Ave.** **P.O. Box 969** **Glenns Ferry, ID 83623**

POLICY NUMBER:	**SR-83116494**
EFFECTIVE DATE:	**August 1, 1999**
ANNIVERSARY DATE:	**August 1**

We agree with the Employer to insure certain eligible employees of the Employer. *We* promise to pay benefits for loss covered by the policy in accordance with its provisions.

The policy is issued in consideration of the payment of premium and the statements made in the Application.

The policy takes effect on the Effective Date stated. All insurance periods will be computed from that date. The policy remains in force for the period for which premium has been paid. It may be renewed for further successive periods by payment of premium as stated in the policy.

All periods of insurance begin and end at 12:01 A.M., Standard Time, at the Employer's address as stated in this contract, and on the application.
DI-1AA

SIGNED FOR THE CONTINENTAL CASUALTY COMPANY

Bernard L. Hengesbaugh
Chairman of the Board

Jonathan Kantor
Secretary

Countersigned by _____
Licensed Resident Agent

Group Long Term Disability Policy

SBDI-P

TABLE OF CONTENTS

Note: All terms in *italics* are listed and defined in the Glossary or within the policy itself.

DI-2AA

SUMMARY OF BENEFITS
Effective As Of: August 1, 1999

LONG TERM DISABILITY PLAN

Policy Effective Date: August 1, 1999

Policy Number: SR-83116494

Eligibility: All active full-time employees who are *Actively at Work* for the Employer.

Definition of Full-time: Employees must be working at least 30 hours per week.

Waiting Period: For employees in an eligible group on or before August 1, 1999: 30 Days of continuous active, full-time employment.
For employees entering an eligible group after August 1, 1999: 30 Days of continuous active, full-time employment.

Elimination Period: 90 Days

Monthly Benefit: 67% of *Monthly Earnings* to a maximum benefit of $9,000.00 per month subject to reduction by deductible sources of income or *Disability Earnings*.

Social Security Offset Method: Family Social Security

Employer Contribution: 100% of premium

Maximum Period Payable:

Age at *Disability*	Maximum Period Payable
61 or younger	To Retirement Age*
Age 62	42 months or to Retirement Age*, whichever is longer.
Age 63	36 months or to Retirement Age*, whichever is longer.
Age 64	30 months or to Retirement Age*, whichever is longer.
Age 65	24 months or to Retirement Age*, whichever is longer.
Age 66	21 months or to Retirement Age*, whichever is longer.
Age 67	18 months or to Retirement Age*, whichever is longer.
Age 68	15 months or to Retirement Age*, whichever is longer.
Age 69 or over	12 months

***SOCIAL SECURITY NORMAL RETIREMENT AGES**
Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months

1960 or later	67 years

Other features:

Waiver of Premium
Work Incentive Benefit
Enhanced Work Incentive Benefit
Minimum Benefit
Recurrent Disability
FMLA Coverage Extension
Survivor Benefit
Day Care Benefit
Worksite Modification Benefit
Vocational Rehabilitation Service
Social Security Assistance
Presumptive Disability

This Summary of Benefits cancels and replaces all other Summaries previously issued under the policy. It outlines the policy features. The following pages provide a complete description of the provisions of the policy.
SOBP

HOW IS PREMIUM CALCULATED?
Premium is calculated by multiplying the total insured *Monthly Earnings* by .0083. Do not include *Monthly Earnings* for any individual in excess of $13,432.84 per Month in the premium calculation.

WHEN IS PREMIUM PAID?
The policy is issued in consideration of the payment in advance of the monthly premium. The monthly premium is calculated at the premium rate stated above. Such payment must be made by the beginning of each monthly premium accounting period and must be accompanied by a premium adjustment report.

If an addition, termination or change in insurance takes place other than on a regular due date, any premium adjustment will take effect on the next due date.

If notice of termination or change is received more than six months after the termination or change became effective, *We* are not required to give a refund or credit for the period in excess of six months.
DI-3AA

IS PREMIUM PAYABLE WHILE AN EMPLOYEE RECEIVES BENEFITS?
We will waive premium for an *Insured Employee* during the period of *Disability* for which the *Monthly Benefit* is payable under the policy. Premium payment is required during the *Insured Employee*'s *Elimination Period.* During this period, the *Insured Employee*'s insurance will remain in force. This provision is subject to the Termination of Employee's Insurance provision, except for payment of premium.
DI-4AA

IS THERE A GRACE PERIOD FOR PREMIUM PAYMENT?
Yes. A grace period of 31 days from the date premium is due is allowed for the payment of premium. The policy will remain in force during the grace period. The Employer is liable for all premiums due for the period the policy remains in force including the grace period, if it applies.
DI-5AA

WHAT IS THE POLICY TERM AND PREMIUM RATE GUARANTEE?
We agree to renew the policy and not to change the premium rate. Such agreement shall be valid until August 1, 2001 if:

1. There are no changes made to the program;
2. There is a minimum of 10 *Insured Employees* and there is less than a 25% change to the number of *Insured Employees* since the effective date of the policy; and
3. There are no new classes of employees, subsidiaries, affiliated companies or new acquisitions of the Employer added after the effective date of the policy.

DI-6AA

WHO MAY CANCEL THE POLICY OR A PLAN UNDER THE POLICY?

The policy or a plan under the policy can be canceled by the Employer.

We may only cancel or offer to modify the policy if:

1. there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
2. there is less than 100% participation of those eligible employees for an Employer paid plan;
3. the Employer does not promptly provide *Us* with information that is reasonably required;
4. the Employer fails to perform any of its obligations that relate to the policy;
5. fewer than 10 employees are insured under the policy;
6. the Employer fails to pay any premium within the 31 day Grace Period.

If *We* cancel the policy, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date.

DI-7AA

WHAT HAPPENS IF AN INADVERTENT ERROR OCCURS?

Clerical error or omissions will not: (1) deprive an employee of insurance which would otherwise have been granted; or (2) effect or continue insurance which otherwise would not be in force. An adjustment of premium will be made.

DI-8AA

WILL CERTIFICATES BE ISSUED?

We will deliver certificates of insurance to the Employer for issuance to each *Insured Employee*. The certificates will describe the benefits, to whom they are payable, the policy limitations and where the policy may be inspected.

DI-9AA

Continental Casualty Company

CNA
For All the Commitments You Make®

CNA Plaza A Stock Company
Chicago, Illinois 60685

Having issued Policy No. SR-83116494 to

Rural & Pend Oreille Telephone Companies
(Herein called the Employer)

CERTIFIES that *You* are insured provided that *You* qualify under the ELIGIBILITY provision, become insured and remain insured in accordance with the terms of the policy. *Your* insurance is subject to all the definitions, limitations and conditions of the policy. It takes effect on the effective date indicated in the EFFECTIVE DATE provision. This certificate, however, is not the policy. It is merely evidence of insurance provided under the policy. The policy can be amended by mutual consent between the Employer and *Us*.

This certificate replaces and cancels any other certificate previously issued to *You* under the policy.
CDI-1AA

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, *We* have discretionary authority to determine *Your* eligibility for benefits and to interpret the terms and provisions of the policy.
CDI-2AA

Bernard L. Hengesbaugh
Chairman of the Board

Group Long Term Disability Certificate

S8DI-C

ARE *YOU* ELIGIBLE FOR THIS INSURANCE?
All active full-time employees who are *Actively at Work* for the Employer and who have completed the waiting period required by the Employer. The waiting period is stated in the *Summary of Benefits*.

A "full-time" employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible.
CDI-4AA

WHEN DOES *YOUR* INSURANCE BECOME EFFECTIVE?
If *You* are eligible as of the Policy Effective Date, *Your* insurance shall take effect on such Date. If *You* become eligible after the Policy Effective Date, *Your* insurance shall become effective on the first of the month that falls on or next follows the date *You* become eligible.

If, because of *Injury* or *Sickness*, *You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.
CDI-5AA

WHO PAYS FOR *YOUR* COVERAGE?
Your employer pays the entire cost of *Your* coverage.
CDI-6AA

IS PREMIUM PAYABLE WHILE *YOU* RECEIVE BENEFITS?
We will waive premium for *You* during the period of *Disability* for which the *Monthly Benefit* is payable under the policy. Premium payment is required during *Your Elimination Period*. During this period, *Your* insurance will remain in force. This provision is subject to the Termination of Employee's Insurance provision, except for payment of premium.
CDI-6BA

HOW DO *WE* DEFINE *DISABILITY*?
Disability or *Disabled* means that *You* satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.
CDI-9AA

Occupation Qualifier
"*Disability*" means that during the *Elimination Period* and the following 24 months, *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:
1. continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*; and
2. not working for wages in any occupation for which *You* are or become qualified by education, training or experience.

CDI-10AA

After the *Monthly Benefit* has been payable for 24 months, "*Disability*" means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:
1. continuously unable to engage in any occupation for which *You* are or become qualified by education, training or experience; and
2. not working for wages in any occupation for which *You* are or become qualified by education, training or experience.

CDI-11AA

Earnings Qualifier
You may be considered *Disabled* during and after the *Elimination Period* in any Month in which *You* are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that *You* are unable to earn more than 80% of *Your Monthly Earnings* in any occupation for which *You* are qualified by education, training or experience. On each anniversary of *Your Disability*, *We* will increase the *Monthly Earnings* by the lesser of the current annual percentage increase in CPI-W, or 10%.

You are not considered to be *Disabled* if *You* earn more than 80% of *Your Monthly Earnings*. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDI-13AA

LOSS OF PROFESSIONAL LICENSE OR CERTIFICATION

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.
CDI-14AA

WHAT IS THE *ELIMINATION PERIOD* AND HOW IS IT SATISFIED?

The *Elimination Period* begins on the day *You* become *Disabled*. It is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. *You* must be continuously *Disabled* through *Your Elimination Period*.

If *You* temporarily recover and return to work, *We* will treat *Your Disability* as continuous if *You* return to work for a period of less than one-half the *Elimination Period* as shown in the *Summary of Benefits* not to exceed 90 days. The days that *You* are not *Disabled* will not count toward *Your Elimination Period*.

Any increases *You* receive in *Monthly Earnings* during *Your* return to work period will not be taken into consideration when calculating *Your Monthly Benefit*.

If *You* return to work for a period greater than one-half the *Elimination Period*, or 90 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period*.

CAN *YOU* SATISFY *YOUR ELIMINATION PERIOD* IF *YOU* ARE WORKING?

Yes, provided *You* meet the definition of *Disability*.
CDI-15AA

WHAT *DISABILITY* BENEFIT ARE *YOU* ELIGIBLE TO RECEIVE?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time: a *Monthly Benefit*, a Work Incentive Benefit or an Enhanced Work Incentive Benefit. While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
CDI-16AA

WHAT IS *YOUR BENEFIT* AND HOW IS IT CALCULATED?

We will calculate *Your Monthly Benefit* amount as follows:

1. Multiply *Your Monthly Earnings* by 67%.
2. The maximum *Monthly Benefit* is $9,000.00.
3. Compare the answers from Item 1 and Item 2: The lesser of these two amounts is *Your* gross *Monthly Benefit*.
4. Deduct other sources of income from *Your* gross *Monthly Benefit*. The resulting figure is *Your* net *Monthly Benefit*.

We will pay the *Monthly Benefit* for each Month of *Disability* which continues after the *Elimination Period*. The *Monthly Benefit* will not be payable during the *Elimination Period* nor beyond the *Maximum Period Payable*.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the *Monthly Benefit* for each day of *Disability*.
CDI-17AA

HOW DO *WE* DEFINE EARNINGS?

"Monthly Earnings" will equal the Monthly wage or salary that *You* were receiving from *Your* employer on the *Date of Disability*. It includes:

1. employee contributions made through a salary reduction agreement with *Your* employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2. amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1. commissions;
2. bonuses;
3. overtime pay;
4. *Your* employer's contribution on *Your* behalf to a *Retirement Plan* or deferred compensation arrangement; or any other extra compensation.

CDI-19AA

WHAT ARE THE DEDUCTIBLE S[redacted].CES OF INCOME?

The *Monthly Benefit* under this policy shall be reduced by:

1. Disability benefits paid, payable, or for which there is a right under:
   a) The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;
   b) Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
   c) Occupational accident coverage provided by or through the Employer;
   d) Any Statutory Disability Benefit Law;
   e) The Railroad Retirement Act;
   f) The Canada Pension Plan, Quebec Pension Plan or any other similar provincial disability or pension plan;
   g) The Canada Old Age Security Act;
   h) Any Public Employee Retirement System Plan or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
2. *Disability* benefits paid under:
   a) Any group insurance plan provided by or through the Employer, and
   b) Any sick leave or salary continuance plan provided by or through the Employer.
3. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement.
4. Retirement and disability benefits paid under a *Retirement Plan* provided by the Employer except for amounts attributable to *Your* contributions.
5. Any No Fault Auto Motor Vehicle coverage.
6. Disbursements received as a shareholder in a Subchapter S Corporation attributable to any period following the *Date of Disability*.

Proration of Lump Sum Awards

If any benefit described above is paid in a single sum through compromise settlement or as an advance on future liability, *We* will determine the amount of reduction to *Your Monthly Benefit* as follows:

1. *We* will divide the amount paid by the number of months for which the settlement or advance was provided; or
2. If the number of months for which the settlement or advance was made is not known, *We* will divide the amount of the settlement or advance by the expected remaining number of months for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 60 months.

CDI-20AA

WHAT OTHER SOURCES OF INCOME ARE NOT DEDUCTIBLE?

We will not reduce *Your Monthly Benefit* by any of the following:

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2. credit disability insurance;
3. pension plans for partners;
4. military pension and disability income plans;
5. franchise disability income plans;
6. individual disability income plans;
7. a *Retirement Plan* from another Employer;
8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

CDI-21AA

CAN *YOU* WORK AND STILL RECEIVE BENEFITS?

While *Disabled, You* may qualify for the Work Incentive Benefit or the Enhanced Work Incentive Benefit, but not both.

CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period*, or after a period during which *You* received *Monthly Benefits*.

The Work Incentive Benefit will be calculated during the first 24 months of *Gainful Employment* as follows:

1. The *Monthly Benefit* amount and *Disability Earnings* amount will be added together and compared to *Monthly Earnings*.
2. If the total amount in Item 1 exceeds 100% of *Monthly Earnings*, the Work Incentive Benefit amount will be equal to the *Monthly Benefit* reduced by the amount of the excess.

3. If the total amount in Item 1 do[redacted]ot exceed 100% of *Monthly Earnings*, the[redacted]rk Incentive Benefit will be equal to the *Monthly Benefit* amount.

After the first 24 months of *Gainful Employment*, the Work Incentive Benefit will be equal to the *Monthly Benefit* amount less 50% of *Disability Earnings*.

The Work Incentive Benefit will cease on the earliest of the following: (1) the date *You* are no longer *Disabled;* or (2) the end of the *Maximum Period Payable*.
CDI-23AA

Enhanced Work Incentive Benefit
An Enhanced Work Incentive Benefit will be provided after the end of the *Elimination Period*, or after a period during which *You* received *Monthly Benefits*. This benefit is payable if *You* are still *Disabled* and are *Gainfully Employed* in an occupation that has been approved as part of a *Rehabilitation Plan*.

The Enhanced Work Incentive Benefit will be calculated during the first 24 months of *Gainful Employment* as follows:
1. If *Disability Earnings* exceed 100% of *Monthly Earnings*, the Enhanced Work Incentive Benefit will be equal to the *Monthly Benefit* reduced by the amount of the excess.
2. If *Disability Earnings* do not exceed 100% of *Monthly Earnings*, the Enhanced Work Incentive Benefit will be equal to the *Monthly Benefit*.

After the first 24 months of *Gainful Employment*, the Enhanced Work Incentive Benefit will be equal to the *Monthly Benefit* less 50% of *Disability Earnings*.

The Enhanced Work Incentive Benefit will cease on the earliest of the following: (1) as stated in the *Rehabilitation Plan;* (2) the date *You* fail to comply with the requirements of the *Rehabilitation Plan;* (3) the date *You* are no longer *Disabled;* or (4) at the end of the *Maximum Period Payable*.
CDI-24AA

WHAT IS THE MINIMUM *MONTHLY BENEFIT* PAYABLE UNDER THIS PROGRAM?
In no event will the *Monthly Benefit* payable for *Disability* be reduced to less than $100.00 or 10% of *Your Monthly Benefit* prior to the reductions stated above, whichever is greater. The Minimum *Monthly Benefit* does not apply if *You* are *Gainfully Employed.*
CDI-25AA

WHAT HAPPENS IF *YOUR* OTHER BENEFITS INCREASE?
The *Monthly Benefit*, after the reductions stated above, if any, will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which there is a right under any Deductible Source of Income shown above.
CDI-26AA

HOW LONG WILL *YOU* RECEIVE BENEFITS UNDER THIS PROGRAM?
We send *You* a payment each month up to the maximum duration of benefit based on *Your* age at *Disability* so long as *You* continue to be *Disabled* according to the terms of the policy:

Age at *Disability*	Maximum Period Payable
61 or younger	To Retirement Age*
Age 62	42 months or to Retirement Age*, whichever is longer.
Age 63	36 months or to Retirement Age*, whichever is longer.
Age 64	30 months or to Retirement Age*, whichever is longer.
Age 65	24 months or to Retirement Age*, whichever is longer.
Age 66	21 months or to Retirement Age*, whichever is longer.
Age 67	18 months or to Retirement Age*, whichever is longer.
Age 68	15 months or to Retirement Age*, whichever is longer.
Age 69 or over	12 months

***SOCIAL SECURITY NORMAL RETIREMENT AGES**
Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years

CDI-27AA

WHAT HAPPENS IF *YOUR DISABILITY* RECURS?
If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 6 months after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the policy that were in effect at the time the prior *Disability* began.

Disability which recurs more than 6 months after the end of a prior *Disability* are subject to:
1) a new *Elimination Period*;
2) a new *Maximum Period Payable*; and
3) the other provisions of the policy that are in effect on the date the *Disability* recurs.

Disability must recur while *Your* coverage is in force under the policy.
CDI-28AA

WHAT ARE THE EXCLUSIONS AND LIMITATIONS UNDER THIS PROGRAM?
The policy does not cover any loss caused by, contributed to, or resulting from:
CDIX-1AA

- declared or undeclared war or an act of either;

CDIX-2AA

- *Disability* beyond 24 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit;

CDIX-3AA

- a *Pre-existing Condition*;

CDIX-4AA

- attempted suicide, while sane or insane, or intentional self-inflicted *injury* or *sickness*;

CDIX-5AA

- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.

CDIX-6AA

- *Disability* beyond 24 months after the *Elimination Period* if it is due to a diagnosed condition which manifests itself primarily with *Self-Reported Symptom(s)*.

CDIX-7AA

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
CDIX-12AA

Benefits will not be payable if it is determined that *You* are eligible to participate in vocational rehabilitation services designed to assist in returning *You* to employment and *You* refuse to participate.
CDIX-13AA

HOW ARE SUBSTANCE ABUSE CLAIMS HANDLED?
The policy does not cover any loss caused by or resulting from any substance abuse (drug or alcohol) related *Disability* beyond 24 months after the *Elimination Period*.

You must be participating in an appropriate treatment program. A treatment program is any substance abuse treatment program approved by the State.

The cost of the treatment program will be borne by *You*, or another group plan of *Your* Employer (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

In no event will *Monthly Benefit* payments be made beyond the earlier of the date:
1. 24 *Monthly Benefit* payments have been made; or
2. *You* refuse to participate in an appropriate, available treatment program, or *You* leave the treatment program prior to completion; or
3. *You* are no longer following the requirements of *Your* treatment plan under the program; or
4. *You* complete the initial treatment plan, exclusive of any aftercare or follow-up services.

In no event will *Monthly Benefits* be payable beyond the *Maximum Period Payable*.
CDI-29AA

WHEN WILL *YOUR* INSURANCE TERMINATE?
Your coverage will terminate on the earliest of the following dates:
1. the date the policy is terminated; or
2. the premium due date if the Employer fails to pay the required premium for *You*, except for an inadvertent error; or
3. the date *You:*
   (a) are no longer a member of a class eligible for this insurance, or
   (b) withdraw from the program, or
   (c) are retired or pensioned, or
   (d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the Employer have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination.
CDI-30AA

WILL COVERAGE BE CONTINUED IF *YOU* ARE ELIGIBLE FOR LEAVE UNDER FMLA?
In the event *You* are eligible for and *Your* Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the Employer continues paying the required premium.

You are eligible for leave under this Act in order to provide care:
1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or
4. To a *Spouse*, child or parent due to their serious illness; or
5. For *Your* own serious health condition.

While granted a Family and Medical Leave Absence:
1. The Employer will pay the required premium according to the terms of the policy;
2. *You* will be considered *Actively at Work* while on an approved Family and Medical Leave Absence; and
3. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the Employer.

CDI-31AA

WHAT HAPPENS IF *YOU* DIE WHILE RECEIVING BENEFITS?
If *You* die after having received the benefit provided by the policy for at least 12 successive months and during a period for which benefits are payable, *We* will pay a Survivor Income Benefit. This benefit is equal to the amount *You* were last entitled to receive for the month preceding death.

The Survivor Income Benefit shall be payable on a monthly basis immediately after *We* receive written proof of *Your* death. It is payable for 6 months. The benefit shall accrue from *Your* date of death.

This benefit is payable to the beneficiary, if any, named by *You* under the policy. If no such beneficiary exists, the benefit will be payable in accordance with the TIME AND PAYMENT OF CLAIM provision.
CDI-33AA

ARE DAY CARE EXPENSE BENEFITS AVAILABLE WHILE *YOU* ARE *DISABLED*?
While *Disabled* and receiving the Enhanced Work Incentive Benefit, *You* will be reimbursed for Day Care Expenses for each Eligible Child.

"Day Care Expenses" mean monthly expenses, up to $350.00 per child per month, charged by a licensed Day Care Provider who is not a member of *Your immediate family* or living in *Your* residence.

"Eligible Child" is *Your* dependent child under age 13 who lives with *You* and is:
1. *Your* child or *Your Spouse*'s child;
2. *Your* legally adopted child; or
3. A child for whom *You* are legal guardian.

You must supply satisfactory proof to *Us* that *You* incurred such charges.
CDI-34AA

WHAT OTHER SERVICES ARE AVAILABLE TO *YOU* WHILE *YOU* ARE *DISABLED*?
If *You* are *Disabled* and eligible to receive *Disability* benefits under the policy, *We* will evaluate *You* for eligibility to receive any of the following. *We* will make the final determination for any of the following benefits or services.

Worksite Modification Benefit
We will assist *You* and *Your* employer in identifying modifications *We* agree are likely to help *You* remain at work or return to work. This agreement will be in writing and must be signed by *You*, *Your* employer and *Us*.

When this occurs, *We* will reimburse *Your* employer for the cost of the modification, up to the greater of: 1) $1,500.00 or 2) 2 months of *Your* net *Monthly Benefit*.

Vocational Rehabilitation Service
Rehabilitation services are available when *We* determine that these services are reasonably assumed to assist in returning *You* to *Gainful Employment*. Vocational Rehabilitation services might include one or more of the following:
1. job modification;
2. job retraining;
3. job placement;
4. other activities.

Eligibility for Vocational Rehabilitation Services is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:
1. *Your Disability* must prevent *You* from performing *Your Regular Occupation;*
2. *You* must have the physical and/or mental capacities necessary for successful completion of a rehabilitation program, and
3. There must be a reasonable expectation that rehabilitation services will help *You* return to *Gainful Employment*.

Social Security Assistance
When necessary, *We* will provide an advocate for *You*, in applying for and securing Social Security *Disability* awards. When *We* determine that Social Security Assistance is appropriate for *You*, it is provided at no additional cost to *You*.
CDI-35AA

WHAT OTHER BENEFITS ARE AVAILABLE?
CDIO-1AA

PRESUMPTIVE DISABILITY

When *Injury* results in any of the Specific Losses listed below within 365 days after the date of the *Injury*, *We* will consider *You* to be *Disabled*. *You* shall be entitled to payment of the *Monthly Benefit* after the *Elimination Period*. This benefit is payable for the length of time stated below. Payment of the Presumptive Disability Benefit will cease on *Your* date of death.

Specific Loss	Months Payable
Loss of both hands	46 months
Loss of both feet	46 months
Loss of the entire sight of both eyes	46 months
Loss of one hand and one foot	46 months
Loss of one hand and the entire sight of one eye	46 months
Loss of one foot and the entire sight of one eye	46 months
Loss of one hand	23 months
Loss of one foot	23 months
Loss of the entire sight of one eye	15 months
Loss of the thumb and index finger of either hand	12 months

After payment of this Minimum Benefit, benefits may continue subject to the other provisions of the policy. If more than one loss results from any one *Injury*, *We* will pay only for that loss with the greatest number of Months Payable.

"Specific Loss" means, with respect to hand or foot, the actual, complete and permanent severance through or above the wrist or ankle joint; with respect to eye, the irrecoverable loss of the entire sight thereof; and with respect to thumb and index finger, the actual, complete and permanent severance through or above the metacarpophalangeal joints.
CDIO-10AA

WHAT ARE THE CLAIM FILING REQUIREMENTS?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible so that *We* may make a timely decision on *Your* claim. *Your* Employer can assist *You* with the appropriate telephone number and address of Our Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to Our Claim Department, the CNA Home Office, CNA Plaza, Chicago, Illinois 60685 or given to Our Agent.

Written Proof of Loss

Within 15 days of our being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, *Your* Employer and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof which describes the occurrence, extent and nature of loss.

Time Limit for Filing *Your* Claim

The time limit for filing *Your* claim is that *You* must furnish *Us* with written proof of loss within 90 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is stated in the *Summary of Benefits* section of the policy. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1. It was not reasonably possible to give written proof during the 1 year period, and
2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of Disability

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to do so may delay, suspend or terminate *Your* benefits:

1. The date *Your Disability* began;
2. The cause of *Your Disability*;
3. The prognosis of *Your Disability*;

4. Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your immediate family*, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5. Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6. The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7. Appropriate documentation of *Your Monthly Earnings*. If applicable, appropriate, regular monthly documentation of *Your Disability Earnings*.
8. If *You* were contributing to the premium cost, *Your* employer must supply proof of *Your* appropriate payroll deductions.
9. The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10. If applicable, proof of incurred costs covered under other benefits included in the policy.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request.

Physical Examination

At *Our* expense, *We* have the right to have a *Doctor* examine *You* as often as reasonably necessary while the claim continues. Failure to comply with this examination will suspend or terminate benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* Will Be Asked to Supply

1. *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information which support *Your Disability* claim. Failure to submit this information will deny, suspend or terminate *Your* benefits.
2. *You* will be required to supply proof that *You* have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3. *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Income Benefits. *You* must tell *Us* the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AA

TIME AND PAYMENT OF CLAIM

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid on a Monthly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your:* (1) *Spouse*; (2) children including legally adopted children; (3) parents; or (4) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

CDI-37AA

CAN YOU ASSIGN YOUR BENEFITS?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

CDI-38AA

WHAT WILL HAPPEN IF A CLAIM IS OVERPAID?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income; when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs.

In an overpayment situation, *We* determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery. If *Monthly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the Minimum Monthly Benefit payable under the policy.

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the policy.
CDI-39AA

WHAT ARE THE UNIFORM PROVISIONS?

Entire Contract; Changes

The policy, the Employer's application, *Your* certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. No change in the policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Employer or *You*, whoever made the statement. No statement of the Employer will be used to void the policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

Legal Actions

No legal action of any kind may be filed against *Us* :

1. within the 60 days after proof of *Disability* has been given; or
2. more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Conformity with State Statutes

If any provision of the policy conflicts with the statutes of the state in which the policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.
CDI-40AA

SUBROGATION / RIGHT OF REIMBURSEMENT

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*.

We will bear any expenses associated with *Our* pursuit of subrogation or recovery.
CDI-41AA

FRAUD

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.
CDI-42AA

GENERAL PROVISIONS

We have the right to inspect all of the Employer's records on the policy at any reasonable time. This right will extend until: (1) 2 years after termination of the policy; or (2) all claims under the policy have been settled, whichever is later.

The policy is in the Employer's possession and may be inspected by *You* at any time during normal business hours at the Employer's office.

The policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
CDI-43AA

"Actively at Work" or ***"Active Work"*** means the employee must be:

1. working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
2. performing the *Material and Substantial Duties* of the *Insured Employee*'s *Regular Occupation* on a full-time basis.

CDID-1AA

"Appropriate and Regular Care" means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.
CDID-4AA

"Date of Disability" is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Occupation*.
CDID-5AA

"Disability" or ***"Disabled"*** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.
CDID-6AA

"Disability Earnings" is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It does not include Social Security or any other *Disability* payment *You* receive as a result of *Your Disability*.
CDID-7AA

"Doctor" means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.
CDID-8AA

"Elimination Period" means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Summary of Benefits*.
CDID-9AA

"Gainful Employment" or ***"Gainfully Employed"*** means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, for the Employer or another employer, and which *We* approve and for which *We* reserve the right to modify approval in the future.
CDID-10AA

"Generally Accepted Medical Practice" or ***"Generally Accepted in the Practice of Medicine"*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
CDID-11AA

"Hospital or Health Care Facility" is a legally operated, accredited facility licensed to provide full-time care and treatment for condition causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.
CDID-12AA

"Injury" means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.
CDID-13AA

"Insured Employee" means an employee whose insurance is in force under the terms of the policy.
CDID-14AA

"Male pronoun" whenever used includes the female.
CDID-16AA

"Material and Substantial Duties" means the necessary functions of *Your Regular Occupation* which cannot be reasonably omitted or altered.
CDID-17AA

"Maximum Medical Improvement" is that level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
CDID-18AA

"Mental Disorder" means a disorder found in the current diagnostic standards in the American Psychiatric Association.
CDID-19AA

"Monthly Benefit" and ***"Maximum Period Payable"*** mean that benefit and those periods shown in the *Summary of Benefits* which apply to *You*.
CDID-20AA

"Pre-existing Condition" means a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to *Your* effective date of insurance. A condition shall no longer be considered pre-existing if it causes *Disability* which begins after *You* have been insured under the policy for a period of 12 months.
CDID-21BA

"Regular Occupation" means the occupation that *You* are performing for income or wages on *Your Date of Disability*. It is not limited to the specific position *You* held with *Your* employer.
CDID-22BA

"Rehabilitation Plan" means a written agreement between *You* and *Us*. Its purpose is to assist *You* in returning to *Gainful Employment*. The *Rehabilitation Plan* will outline the time and dates of the vocational rehabilitation services, *Our* responsibilities, *Your* responsibilities and the responsibilities of any third party which might be involved. The *Rehabilitation Plan* will be at *Our* expense, at the expense of the third party, or a shared expense of *Ours* and a third party. At *Our* discretion, the *Rehabilitation Plan* will include the Day Care Expense Benefit.
CDID-23AA

"Retirement Plan" means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

"Self-Reported Symptoms" means the symptoms of which *You* tell *Your Doctor*, and are not verifiable or quantifiable using tests, procedures, or clinical examinations *Generally Accepted in the Practice of Medicine*. Examples of these manifestations include the following, but are not limited to: fatigue, pain, headaches, stiffness, soreness, tinnitus (ringing in the ears), dizziness, numbness, or loss of energy.
CDID-25AA

"Sickness" means sickness or disease causing *Disability* which begins while *Your* coverage is in force.
CDID-26AA

"Summary of Benefits" means the summary which is a part of this certificate.
CDID-28AA

"We", ***"Our"*** and ***"Us"*** mean the Continental Casualty Company, Chicago, Illinois.
CDID-29AA

"You", ***"Your"*** and ***"Yours"*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the policy.
CDID-30AA

ERISA

YOUR RIGHTS UNDER ERISA

The following section contains information provided to *You* by the Plan Administrator of *Your* Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan
The Plan for which this Summary Plan Description is provided is known as the:

Rural & Pend Oreille Telephone Companies Group Disability Plan

Maintenance of Plan
The Plan is maintained by:

Rural & Pend Oreille Telephone Companies
104 West Madison Ave.
Glenns Ferry, ID 83623

Employer Identification Number and Plan Number
The employer identification number (EIN) assigned by the Internal Revenue Service to the Plan sponsor is:
93-0739703
The Plan Number assigned by the Plan sponsor is:

Type of Welfare Plan
The Plan is a group disability plan.

Administration of Plan
The Plan is administered by the Plan Administrator through an insurance contract purchased from Continental Casualty Company.

Plan Administrator

Rural & Pend Oreille Telephone Companies
104 West Madison Ave.
Glenns Ferry, ID 83623

Hereinafter referred to as the Administrator. The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan.

Agent for Service of Legal Process
The person designated as agent for service of legal process upon the Plan is:

Rural & Pend Oreille Telephone Companies
104 West Madison Ave.
Glenns Ferry, ID 83623

In addition, service of process may be made upon the Administrator.

Eligibility and Benefits
The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits and description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits
Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

Sources of Plan Contributions
Contributions to the Plan are made by the employer.

Medium for Providing Benefits
Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number SR-83116494 issued by Continental Casualty Company, CNA Plaza, Chicago, Illinois, 60685.

Date of End of Plan's Fiscal Year
The date of the end of each year for purposes of maintaining the Plan's fiscal records is December 31.

Claim Procedures

1. Presenting Claims for Benefits
   Claim forms may be obtained from: the Employer.

   Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

2. Claims Denial Procedure
   Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information *You* might be required to provide and an explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure. *You*, *Your* beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. *You* may have representation throughout the review procedure. A request for a review must be filed by 60 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 60 days after receipt of the request for the review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days after receipt of the request for the review. If such an extension of time is needed, *You* will be notified in writing prior to the beginning of the time extension period. The decision after *Your* review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

Statement of ERISA Rights
The statement of ERISA Rights is required by federal law and regulation.

As a participant in this Plan *You* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate *Your* Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of *You* and other Plan participants and beneficiaries.

No one, including *Your* employer, *Your* union, or any other person, may fire *You* or otherwise discriminate against *You* in any way to prevent *You* from obtaining a welfare benefit or exercising *Your* rights under ERISA.

If Your claim for a welfare benefit is denied in whole or in part, *You* must receive a written explanation of the reason for the denial. *You* have the right to have the insurance company review and reconsider *Your* claim.

Under ERISA, there are steps *You* can take to enforce the above rights. For instance, if *You* request materials for the Plan and do not receive them within 30 days, *You* may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay *You* up to $110 a day until *You* receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If *You* have a claim for benefits which is denied or ignored, in whole or in part, *You* may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if *You* are discriminated against for asserting *Your* rights, *You* may seek assistance from the U.S. Department of Labor, or *You* may file suit in a federal court. The court will decide who should pay court costs and legal fees. If *You* are successful, the court may order the person *You* have sued to pay the cost and fees. If *You* lose, the court may order *You* to pay these costs and fees, for example, if it finds *Your* claim is frivolous.

If *You* have any questions about *Your* Plan, *You* should contact the Administrator. If *You* have any questions about this statement or about *Your* rights under ERISA, *You* should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in *Your* telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
ERISA

Continental Casualty Company

CNA
For All the Commitments You Make®

CNA Plaza A Stock Company
Chicago, Illinois 60685

APPLICATION

is hereby made to the Continental Casualty Company for Group Disability Income Insurance by

1. Employer: **Rural & Pend Oreille Telephone Companies**

2. Address: 104 West Madison Ave.
P.O. Box 969
Glenns Ferry, ID 83623

3. To be effective in the State of IDAHO and governed by the laws thereof.

4. Coverage applied for : Policy #: **SR-83116494**

☐ Short Term Disability

☒ Long Term Disability

5. Eligibility:
The classes of individuals eligible for coverage are identified in the policy.

6. Effective Date:
The policy(ies) applied for will become effective at 12:01 A.M. Standard Time at the Applicant's address on August 1, 1999 provided the Application is accepted in writing by the Continental Casualty Company at its Home Office, CNA Plaza, Chicago, Illinois, 60685. It is agreed that the policy(ies) cannot become effective until a deposit premium has been paid and, as to benefits requiring contributions by the individuals insured, until at least 75% of the individuals eligible have subscribed to the policy. The Applicant further agrees that, as to benefits not requiring contributions by the individuals insured, all eligible individuals will be insured.

By: _____
Applicant

WITNESS: _____
Licensed Resident Agent

_____
Title

_____
Date

SBDI-Z

Continental Casualty Company

CNA
For All the Commitments You Make®

CNA Plaza A Stock Company
Chicago, Illinois 60685

Having issued Policy No. SR-83116494 to

Rural & Pend Oreille Telephone Companies
(Herein called the Employer)

CERTIFIES that *You* are insured provided that *You* qualify under the ELIGIBILITY provision, become insured and remain insured in accordance with the terms of the policy. *Your* insurance is subject to all the definitions, limitations and conditions of the policy. It takes effect on the effective date indicated in the EFFECTIVE DATE provision. This certificate, however, is not the policy. It is merely evidence of insurance provided under the policy. The policy can be amended by mutual consent between the Employer and *Us*.

This certificate replaces and cancels any other certificate previously issued to *You* under the policy.
CDI-1AA

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, *We* have discretionary authority to determine *Your* eligibility for benefits and to interpret the terms and provisions of the policy.
CDI-2AA

Bernard L. Hengesbaugh
Chairman of the Board

Group Long Term Disability Certificate

S8DI-C

TABLE OF CONTENTS

TITLE **PAGE**

Note: All terms in *italics* are listed and defined in the Glossary or within the certificate itself.

CDI-3AA

SUMMARY OF BENEFITS
Effective As Of: August 1, 1999

LONG TERM DISABILITY PLAN

Policy Effective Date: August 1, 1999
Policy Number: SR-83116494

Eligibility: All active full-time employees who are *Actively at Work* for the Employer.

Definition of Full-time: Employees must be working at least 30 hours per week.

Waiting Period: For employees in an eligible group on or before August 1, 1999: 30 Days of continuous active, full-time employment.
For employees entering an eligible group after August 1, 1999: 30 Days of continuous active, full-time employment.

Elimination Period: 90 Days

Monthly Benefit: 67% of *Monthly Earnings* to a maximum benefit of $9,000.00 per month subject to reduction by deductible sources of income or *Disability Earnings.*

Social Security Offset Method: Family Social Security

Employer Contribution: 100% of premium

Maximum Period Payable:

Age at *Disability*	Maximum Period Payable
61 or younger	To Retirement Age*
Age 62	42 months or to Retirement Age*, whichever is longer.
Age 63	36 months or to Retirement Age*, whichever is longer.
Age 64	30 months or to Retirement Age*, whichever is longer.
Age 65	24 months or to Retirement Age*, whichever is longer.
Age 66	21 months or to Retirement Age*, whichever is longer.
Age 67	18 months or to Retirement Age*, whichever is longer.
Age 68	15 months or to Retirement Age*, whichever is longer.
Age 69 or over	12 months

***SOCIAL SECURITY NORMAL RETIREMENT AGES**
Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years

Other features:

Waiver of Premium
Work Incentive Benefit
Enhanced Work Incentive Benefit
Minimum Benefit
Recurrent Disability
FMLA Coverage Extension
Survivor Benefit
Day Care Benefit
Worksite Modification Benefit
Vocational Rehabilitation Service
Social Security Assistance
Presumptive Disability

This Summary of Benefits cancels and replaces all other Summaries previously issued to *You* under the policy. It outlines the policy features. The following pages provide a complete description of the provisions of *Your* certificate.
SOBC

ARE *YOU* ELIGIBLE FOR THIS INSURANCE?
All active full-time employees who are *Actively at Work* for the Employer and who have completed the waiting period required by the Employer. The waiting period is stated in the *Summary of Benefits.*

A "full-time" employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible.
CDI-4AA

WHEN DOES *YOUR* INSURANCE BECOME EFFECTIVE?
If *You* are eligible as of the Policy Effective Date, *Your* insurance shall take effect on such Date. If *You* become eligible after the Policy Effective Date, *Your* insurance shall become effective on the first of the month that falls on or next follows the date *You* become eligible.

If, because of *Injury* or *Sickness, You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work.*
CDI-5AA

WHO PAYS FOR *YOUR* COVERAGE?
Your employer pays the entire cost of *Your* coverage.
CDI-6AA

IS PREMIUM PAYABLE WHILE *YOU* RECEIVE BENEFITS?
We will waive premium for *You* during the period of *Disability* for which the *Monthly Benefit* is payable under the policy. Premium payment is required during *Your Elimination Period.* During this period, *Your* insurance will remain in force. This provision is subject to the Termination of Employee's Insurance provision, except for payment of premium.
CDI-6BA

HOW DO *WE* DEFINE *DISABILITY*?
Disability or *Disabled* means that *You* satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.
CDI-9AA

Occupation Qualifier
"*Disability*" means that during the *Elimination Period* and the following 24 months, *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:
1. continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*; and
2. not working for wages in any occupation for which *You* are or become qualified by education, training or experience.

CDI-10AA

After the *Monthly Benefit* has been payable for 24 months, "*Disability*" means the *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

1. continuously unable to engage in any occupation for which *You* are or become qualified by education, training or experience; and
2. not working for wages in any occupation for which *You* are or become qualified by education, training or experience.

CDI-11AA

Earnings Qualifier

You may be considered *Disabled* during and after the *Elimination Period* in any Month in which *You* are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that *You* are unable to earn more than 80% of *Your Monthly Earnings* in any occupation for which *You* are qualified by education, training or experience. On each anniversary of *Your Disability*, *We* will increase the *Monthly Earnings* by the lesser of the current annual percentage increase in CPI-W, or 10%.

You are not considered to be *Disabled* if *You* earn more than 80% of *Your Monthly Earnings.* Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

CDI-13AA

LOSS OF PROFESSIONAL LICENSE OR CERTIFICATION

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.

CDI-14AA

WHAT IS THE *ELIMINATION PERIOD* AND HOW IS IT SATISFIED?

The *Elimination Period* begins on the day *You* become *Disabled*. It is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. *You* must be continuously *Disabled* through *Your Elimination Period*.

If *You* temporarily recover and return to work, *We* will treat *Your Disability* as continuous if *You* return to work for a period of less than one-half the *Elimination Period* as shown in the *Summary of Benefits* not to exceed 90 days. The days that *You* are not *Disabled* will not count toward *Your Elimination Period*.

Any increases *You* receive in *Monthly Earnings* during *Your* return to work period will not be taken into consideration when calculating *Your Monthly Benefit*.

If *You* return to work for a period greater than one-half the *Elimination Period*, or 90 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period*.

CAN *YOU* SATISFY *YOUR ELIMINATION PERIOD* IF *YOU* ARE WORKING?

Yes, provided *You* meet the definition of *Disability*.

CDI-15AA

WHAT *DISABILITY* BENEFIT ARE *YOU* ELIGIBLE TO RECEIVE?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time: a *Monthly Benefit*, a Work Incentive Benefit or an Enhanced Work Incentive Benefit. While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.

CDI-16AA

WHAT IS *YOUR BENEFIT* AND HOW IS IT CALCULATED?

We will calculate *Your Monthly Benefit* amount as follows:

1. Multiply *Your Monthly Earnings* by 67%.
2. The maximum *Monthly Benefit* is $9,000.00.
3. Compare the answers from Item 1 and Item 2: The lesser of these two amounts is *Your* gross *Monthly Benefit*.
4. Deduct other sources of income from *Your* gross *Monthly Benefit*. The resulting figure is *Your* net *Monthly Benefit*.

We will pay the *Monthly Benefit* for each Month of *Disability* which continues after the *Elimination Period*. The *Monthly Benefit* will not be payable during the *Elimination Period* nor beyond the *Maximum Period Payable*.

If a benefit is payable for less than a month, it will be paid on the basis of 1/30th of the *Monthly Benefit* for each day of *Disability*.
CDI-17AA

HOW DO *WE* DEFINE EARNINGS?
"Monthly Earnings" will equal the Monthly wage or salary that *You* were receiving from *Your* employer on the *Date of Disability*. It includes:
1. employee contributions made through a salary reduction agreement with *Your* employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2. amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:
1. commissions;
2. bonuses;
3. overtime pay;
4. *Your* employer's contribution on *Your* behalf to a *Retirement Plan* or deferred compensation arrangement; or any other extra compensation.

CDI-19AA

WHAT ARE THE DEDUCTIBLE SOURCES OF INCOME?
The *Monthly Benefit* under this policy shall be reduced by:
1. Disability benefits paid, payable, or for which there is a right under:
   a) The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;
   b) Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
   c) Occupational accident coverage provided by or through the Employer;
   d) Any Statutory Disability Benefit Law;
   e) The Railroad Retirement Act;
   f) The Canada Pension Plan, Quebec Pension Plan or any other similar provincial disability or pension plan;
   g) The Canada Old Age Security Act;
   h) Any Public Employee Retirement System Plan or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
2. *Disability* benefits paid under:
   a) Any group insurance plan provided by or through the Employer, and
   b) Any sick leave or salary continuance plan provided by or through the Employer.
3. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement.
4. Retirement and disability benefits paid under a *Retirement Plan* provided by the Employer except for amounts attributable to *Your* contributions.
5. Any No Fault Auto Motor Vehicle coverage.
6. Disbursements received as a shareholder in a Subchapter S Corporation attributable to any period following the *Date of Disability*.

Proration of Lump Sum Awards
If any benefit described above is paid in a single sum through compromise settlement or as an advance on future liability, *We* will determine the amount of reduction to *Your Monthly Benefit* as follows:
1. *We* will divide the amount paid by the number of months for which the settlement or advance was provided; or
2. If the number of months for which the settlement or advance was made is not known, *We* will divide the amount of the settlement or advance by the expected remaining number of months for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 60 months.

CDI-20AA

WHAT OTHER SOURCES OF INCOME ARE NOT DEDUCTIBLE?

We will not reduce *Your Monthly Benefit* by any of the following:

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2. credit disability insurance;
3. pension plans for partners;
4. military pension and disability income plans;
5. franchise disability income plans;
6. individual disability income plans;
7. a *Retirement Plan* from another Employer;
8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

CDI-21AA

CAN *YOU* WORK AND STILL RECEIVE BENEFITS?

While *Disabled, You* may qualify for the Work Incentive Benefit or the Enhanced Work Incentive Benefit, but not both.

CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period,* or after a period during which *You* received *Monthly Benefits*.

The Work Incentive Benefit will be calculated during the first 24 months of *Gainful Employment* as follows:

1. The *Monthly Benefit* amount and *Disability Earnings* amount will be added together and compared to *Monthly Earnings*.
2. If the total amount in Item 1 exceeds 100% of *Monthly Earnings*, the Work Incentive Benefit amount will be equal to the *Monthly Benefit* reduced by the amount of the excess.
3. If the total amount in Item 1 does not exceed 100% of *Monthly Earnings*, the Work Incentive Benefit will be equal to the *Monthly Benefit* amount.

After the first 24 months of *Gainful Employment*, the Work Incentive Benefit will be equal to the *Monthly Benefit* amount less 50% of *Disability Earnings*.

The Work Incentive Benefit will cease on the earliest of the following: (1) the date *You* are no longer *Disabled;* or (2) the end of the *Maximum Period Payable*.

CDI-23AA

Enhanced Work Incentive Benefit

An Enhanced Work Incentive Benefit will be provided after the end of the *Elimination Period,* or after a period during which *You* received *Monthly Benefits*. This benefit is payable if *You* are still *Disabled* and are *Gainfully Employed* in an occupation that has been approved as part of a *Rehabilitation Plan*.

The Enhanced Work Incentive Benefit will be calculated during the first 24 months of *Gainful Employment* as follows:

1. If *Disability Earnings* exceed 100% of *Monthly Earnings*, the Enhanced Work Incentive Benefit will be equal to the *Monthly Benefit* reduced by the amount of the excess.
2. If *Disability Earnings* do not exceed 100% of *Monthly Earnings*, the Enhanced Work Incentive Benefit will be equal to the *Monthly Benefit*.

After the first 24 months of *Gainful Employment*, the Enhanced Work Incentive Benefit will be equal to the *Monthly Benefit* less 50% of *Disability Earnings.*

The Enhanced Work Incentive Benefit will cease on the earliest of the following: (1) as stated in the *Rehabilitation Plan;* (2) the date *You* fail to comply with the requirements of the *Rehabilitation Plan;* (3) the date *You* are no longer *Disabled;* or (4) at the end of the *Maximum Period Payable*.

CDI-24AA

WHAT IS THE MINIMUM *MONTHLY BENEFIT* PAYABLE UNDER THIS PROGRAM?
In no event will the *Monthly Benefit* payable for *Disability* be reduced to less than $100.00 or 10% of *Your Monthly Benefit* prior to the reductions stated above, whichever is greater. The Minimum *Monthly Benefit* does not apply if *You* are *Gainfully Employed*.
CDI-25AA

WHAT HAPPENS IF *YOUR* OTHER BENEFITS INCREASE?
The *Monthly Benefit*, after the reductions stated above, if any, will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which there is a right under any Deductible Source of Income shown above.
CDI-26AA

HOW LONG WILL *YOU* RECEIVE BENEFITS UNDER THIS PROGRAM?
We send *You* a payment each month up to the maximum duration of benefit based on *Your* age at *Disability* so long as *You* continue to be *Disabled* according to the terms of the policy:

Age at *Disability*	Maximum Period Payable
61 or younger	To Retirement Age*
Age 62	42 months or to Retirement Age*, whichever is longer.
Age 63	36 months or to Retirement Age*, whichever is longer.
Age 64	30 months or to Retirement Age*, whichever is longer.
Age 65	24 months or to Retirement Age*, whichever is longer.
Age 66	21 months or to Retirement Age*, whichever is longer.
Age 67	18 months or to Retirement Age*, whichever is longer.
Age 68	15 months or to Retirement Age*, whichever is longer.
Age 69 or over	12 months

***SOCIAL SECURITY NORMAL RETIREMENT AGES**
Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years

CDI-27AA

WHAT HAPPENS IF *YOUR DISABILITY* RECURS?
If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 6 months after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the policy that were in effect at the time the prior *Disability* began.

Disability which recurs more than 6 months after the end of a prior *Disability* are subject to:
1) a new *Elimination Period*;
2) a new *Maximum Period Payable*; and
3) the other provisions of the policy that are in effect on the date the *Disability* recurs.

Disability must recur while *Your* coverage is in force under the policy.
CDI-28AA

WHAT ARE THE EXCLUSIONS AND LIMITATIONS UNDER THIS PROGRAM?
The policy does not cover any loss caused by, contributed to, or resulting from:
CDIX-1AA

- declared or undeclared war or an act of either;
CDIX-2AA

- *Disability* beyond 24 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit;
CDIX-3AA

- a *Pre-existing Condition*;
CDIX-4AA

- attempted suicide, while sane or insane, or intentional self-inflicted *injury* or *sickness*;
CDIX-5AA

- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
CDIX-6AA

- *Disability* beyond 24 months after the *Elimination Period* if it is due to a diagnosed condition which manifests itself primarily with *Self-Reported Symptom(s)*.
CDIX-7AA

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
CDIX-12AA

Benefits will not be payable if it is determined that *You* are eligible to participate in vocational rehabilitation services designed to assist in returning *You* to employment and *You* refuse to participate.
CDIX-13AA

HOW ARE SUBSTANCE ABUSE CLAIMS HANDLED?
The policy does not cover any loss caused by or resulting from any substance abuse (drug or alcohol) related *Disability* beyond 24 months after the *Elimination Period*.

You must be participating in an appropriate treatment program. A treatment program is any substance abuse treatment program approved by the State.

The cost of the treatment program will be borne by *You*, or another group plan of *Your* Employer (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

In no event will *Monthly Benefit* payments be made beyond the earlier of the date:
1. 24 *Monthly Benefit* payments have been made; or
2. *You* refuse to participate in an appropriate, available treatment program, or *You* leave the treatment program prior to completion; or
3. *You* are no longer following the requirements of *Your* treatment plan under the program; or
4. *You* complete the initial treatment plan, exclusive of any aftercare or follow-up services.

In no event will *Monthly Benefits* be payable beyond the *Maximum Period Payable*.
CDI-29AA

WHEN WILL *YOUR* INSURANCE TERMINATE?

Your coverage will terminate on the earliest of the following dates:

1. the date the policy is terminated; or
2. the premium due date if the Employer fails to pay the required premium for *You*, except for an inadvertent error; or
3. the date *You:*
   (a) are no longer a member of a class eligible for this insurance, or
   (b) withdraw from the program, or
   (c) are retired or pensioned, or
   (d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the Employer have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination.

CDI-30AA

WILL COVERAGE BE CONTINUED IF *YOU* ARE ELIGIBLE FOR LEAVE UNDER FMLA?

In the event *You* are eligible for and *Your* Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the Employer continues paying the required premium.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or
4. To a *Spouse*, child or parent due to their serious illness; or
5. For *Your* own serious health condition.

While granted a Family and Medical Leave Absence:

1. The Employer will pay the required premium according to the terms of the policy;
2. *You* will be considered *Actively at Work* while on an approved Family and Medical Leave Absence; and
3. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the Employer.

CDI-31AA

WHAT HAPPENS IF *YOU* DIE WHILE RECEIVING BENEFITS?

If *You* die after having received the benefit provided by the policy for at least 12 successive months and during a period for which benefits are payable, *We* will pay a Survivor Income Benefit. This benefit is equal to the amount *You* were last entitled to receive for the month preceding death.

The Survivor Income Benefit shall be payable on a monthly basis immediately after *We* receive written proof of *Your* death. It is payable for 6 months. The benefit shall accrue from *Your* date of death.

This benefit is payable to the beneficiary, if any, named by *You* under the policy. If no such beneficiary exists, the benefit will be payable in accordance with the TIME AND PAYMENT OF CLAIM provision.

CDI-33AA

ARE DAY CARE EXPENSE BENEFITS AVAILABLE WHILE *YOU* ARE *DISABLED*?

While *Disabled* and receiving the Enhanced Work Incentive Benefit, *You* will be reimbursed for Day Care Expenses for each Eligible Child.

"Day Care Expenses" mean monthly expenses, up to $350.00 per child per month, charged by a licensed Day Care Provider who is not a member of *Your immediate family* or living in *Your* residence.

"Eligible Child" is *Your* dependent child under age 13 who lives with *You* and is:

1. *Your* child or *Your Spouse*'s child;
2. *Your* legally adopted child; or
3. A child for whom *You* are legal guardian.

You must supply satisfactory proof to *Us* that *You* incurred such charges.

CDI-34AA

WHAT OTHER SERVICES ARE AVAILABLE TO *YOU* WHILE *YOU* ARE *DISABLED*?

If *You* are *Disabled* and eligible to receive *Disability* benefits under the policy, *We* will evaluate *You* for eligibility to receive any of the following. *We* will make the final determination for any of the following benefits or services.

Worksite Modification Benefit

We will assist *You* and *Your* employer in identifying modifications *We* agree are likely to help *You* remain at work or return to work. This agreement will be in writing and must be signed by *You*, *Your* employer and *Us*.

When this occurs, *We* will reimburse *Your* employer for the cost of the modification, up to the greater of: 1) $1,500.00 or 2) 2 months of *Your* net *Monthly Benefit*.

Vocational Rehabilitation Service

Rehabilitation services are available when *We* determine that these services are reasonably assumed to assist in returning *You* to *Gainful Employment*. Vocational Rehabilitation services might include one or more of the following:

1. job modification;
2. job retraining;
3. job placement;
4. other activities.

Eligibility for Vocational Rehabilitation Services is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:

1. *Your Disability* must prevent *You* from performing *Your Regular Occupation;*
2. *You* must have the physical and/or mental capacities necessary for successful completion of a rehabilitation program, and
3. There must be a reasonable expectation that rehabilitation services will help *You* return to *Gainful Employment*.

Social Security Assistance

When necessary, *We* will provide an advocate for *You*, in applying for and securing Social Security *Disability* awards. When *We* determine that Social Security Assistance is appropriate for *You*, it is provided at no additional cost to *You*.

CDI-35AA

WHAT OTHER BENEFITS ARE AVAILABLE?

CDIO-1AA

PRESUMPTIVE DISABILITY

When *Injury* results in any of the Specific Losses listed below within 365 days after the date of the *Injury*, *We* will consider *You* to be *Disabled*. *You* shall be entitled to payment of the *Monthly Benefit* after the *Elimination Period*. This benefit is payable for the length of time stated below. Payment of the Presumptive Disability Benefit will cease on *Your* date of death.

Specific Loss	Months Payable
Loss of both hands	46 months
Loss of both feet	46 months
Loss of the entire sight of both eyes	46 months
Loss of one hand and one foot	46 months
Loss of one hand and the entire sight of one eye	46 months
Loss of one foot and the entire sight of one eye	46 months
Loss of one hand	23 months
Loss of one foot	23 months
Loss of the entire sight of one eye	15 months
Loss of the thumb and index finger of either hand	12 months

After payment of this Minimum Benefit, benefits may continue subject to the other provisions of the policy. If more than one loss results from any one *Injury*, *We* will pay only for that loss with the greatest number of Months Payable.

"Specific Loss" means, with respect to hand or foot, the actual, complete and permanent severance through or above the wrist or ankle joint; with respect to eye, the irrecoverable loss of the entire sight thereof; and with respect to thumb and index finger, the actual, complete and permanent severance through or above the metacarpophalangeal joints.

CDIO-10AA

WHAT ARE THE CLAIM FILING REQUIREMENTS?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible so that *We* may make a timely decision on *Your* claim. *Your* Employer can assist *You* with the appropriate telephone number and address of Our Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to Our Claim Department, the CNA Home Office, CNA Plaza, Chicago, Illinois 60685 or given to Our Agent.

Written Proof of Loss

Within 15 days of our being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, *Your* Employer and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof which describes the occurrence, extent and nature of loss.

Time Limit for Filing *Your* Claim

The time limit for filing *Your* claim is that *You* must furnish *Us* with written proof of loss within 90 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is stated in the *Summary of Benefits* section of the policy. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1. It was not reasonably possible to give written proof during the 1 year period, and
2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of Disability

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to do so may delay, suspend or terminate *Your* benefits:

1. The date *Your Disability* began;
2. The cause of *Your Disability*;
3. The prognosis of *Your Disability*;
4. Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your immediate family*, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5. Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6. The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7. Appropriate documentation of *Your Monthly Earnings*. If applicable, appropriate, regular monthly documentation of *Your Disability Earnings*.
8. If *You* were contributing to the premium cost, *Your* employer must supply proof of *Your* appropriate payroll deductions.
9. The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10. If applicable, proof of incurred costs covered under other benefits included in the policy.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request.

Physical Examination

At *Our* expense, *We* have the right to have a *Doctor* examine *You* as often as reasonably necessary while the claim continues. Failure to comply with this examination will suspend or terminate benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* Will Be Asked to Supply

1. *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information which support *Your Disability* claim. Failure to submit this information will deny, suspend or terminate *Your* benefits.
2. *You* will be required to supply proof that *You* have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3. *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Income Benefits. *You* must tell *Us* the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AA

TIME AND PAYMENT OF CLAIM

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid on a Monthly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your:* (1) *Spouse*; (2) children including legally adopted children; (3) parents; or (4) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

CDI-37AA

CAN YOU ASSIGN YOUR BENEFITS?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

CDI-38AA

WHAT WILL HAPPEN IF A CLAIM IS OVERPAID?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income; when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery. If *Monthly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the Minimum Monthly Benefit payable under the policy.

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the policy.

CDI-39AA

WHAT ARE THE UNIFORM PROVISIONS?

Entire Contract; Changes

The policy, the Employer's application, *Your* certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. No change in the policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Employer or *You*, whoever made the statement. No statement of the Employer will be used to void the policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

Legal Actions

No legal action of any kind may be filed against *Us* :

1. within the 60 days after proof of *Disability* has been given; or
2. more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Conformity with State Statutes

If any provision of the policy conflicts with the statutes of the state in which the policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

CDI-40AA

SUBROGATION / RIGHT OF REIMBURSEMENT

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*.

We will bear any expenses associated with *Our* pursuit of subrogation or recovery.

CDI-41AA

FRAUD

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.

CDI-42AA

GENERAL PROVISIONS

We have the right to inspect all of the Employer's records on the policy at any reasonable time. This right will extend until: (1) 2 years after termination of the policy; or (2) all claims under the policy have been settled, whichever is later.

The policy is in the Employer's possession and may be inspected by *You* at any time during normal business hours at the Employer's office.

The policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

CDI-43AA

GLOSSARY

"Actively at Work" or ***"Active Work"*** means the employee must be:

1. working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
2. performing the *Material and Substantial Duties* of the *Insured Employee*'s *Regular Occupation* on a full-time basis.

CDID-1AA

"Appropriate and Regular Care" means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.

CDID-4AA

"Date of Disability" is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Occupation*.

CDID-5AA

"Disability" or ***"Disabled"*** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.

CDID-6AA

"Disability Earnings" is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It does not include Social Security or any other *Disability* payment *You* receive as a result of *Your Disability*.

CDID-7AA

"Doctor" means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.

CDID-8AA

"Elimination Period" means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Summary of Benefits*.

CDID-9AA

"Gainful Employment" or ***"Gainfully Employed"*** means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, for the Employer or another employer, and which *We* approve and for which *We* reserve the right to modify approval in the future.

CDID-10AA

"Generally Accepted Medical Practice" or ***"Generally Accepted in the Practice of Medicine"*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

CDID-11AA

"Hospital or Health Care Facility" is a legally operated, accredited facility licensed to provide full-time care and treatment for condition causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.

CDID-12AA

"Injury" means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.

CDID-13AA

"Insured Employee" means an employee whose insurance is in force under the terms of the policy.

CDID-14AA

"Male pronoun" whenever used includes the female.

CDID-16AA

"Material and Substantial Duties" means the necessary functions of *Your Regular Occupation* which cannot be reasonably omitted or altered.

CDID-17AA

"Maximum Medical Improvement" is that level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
CDID-18AA

"Mental Disorder" means a disorder found in the current diagnostic standards in the American Psychiatric Association.
CDID-19AA

"Monthly Benefit" and ***"Maximum Period Payable"*** mean that benefit and those periods shown in the *Summary of Benefits* which apply to *You*.
CDID-20AA

"Pre-existing Condition" means a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to *Your* effective date of insurance. A condition shall no longer be considered pre-existing if it causes *Disability* which begins after *You* have been insured under the policy for a period of 12 months.
CDID-21BA

"Regular Occupation" means the occupation that *You* are performing for income or wages on *Your Date of Disability*. It is not limited to the specific position *You* held with *Your* employer.
CDID-22BA

"Rehabilitation Plan" means a written agreement between *You* and *Us*. Its purpose is to assist *You* in returning to *Gainful Employment*. The *Rehabilitation Plan* will outline the time and dates of the vocational rehabilitation services, *Our* responsibilities, *Your* responsibilities and the responsibilities of any third party which might be involved. The *Rehabilitation Plan* will be at *Our* expense, at the expense of the third party, or a shared expense of *Ours* and a third party. At *Our* discretion, the *Rehabilitation Plan* will include the Day Care Expense Benefit.
CDID-23AA

"Retirement Plan" means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

"Self-Reported Symptoms" means the symptoms of which *You* tell *Your Doctor*, and are not verifiable or quantifiable using tests, procedures, or clinical examinations *Generally Accepted in the Practice of Medicine*. Examples of these manifestations include the following, but are not limited to: fatigue, pain, headaches, stiffness, soreness, tinnitus (ringing in the ears), dizziness, numbness, or loss of energy.
CDID-25AA

"Sickness" means sickness or disease causing *Disability* which begins while *Your* coverage is in force.
CDID-26AA

"Summary of Benefits" means the summary which is a part of this certificate.
CDID-28AA

"We", ***"Our"*** and ***"Us"*** mean the Continental Casualty Company, Chicago, Illinois.
CDID-29AA

"You", ***"Your"*** and ***"Yours"*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the policy.
CDID-30AA

ERISA

YOUR RIGHTS UNDER ERISA

The following section contains information provided to *You* by the Plan Administrator of *Your* Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan
The Plan for which this Summary Plan Description is provided is known as the:

Rural & Pend Oreille Telephone Companies Group Disability Plan

Maintenance of Plan
The Plan is maintained by:

Rural & Pend Oreille Telephone Companies
104 West Madison Ave.
Glenns Ferry, ID 83623

Employer Identification Number and Plan Number
The employer identification number (EIN) assigned by the Internal Revenue Service to the Plan sponsor is:
93-0739703
The Plan Number assigned by the Plan sponsor is:
Type of Welfare Plan
The Plan is a group disability plan.

Administration of Plan
The Plan is administered by the Plan Administrator through an insurance contract purchased from Continental Casualty Company.

Plan Administrator

Rural & Pend Oreille Telephone Companies
104 West Madison Ave.
Glenns Ferry, ID 83623

Hereinafter referred to as the Administrator. The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan.

Agent for Service of Legal Process
The person designated as agent for service of legal process upon the Plan is:

Rural & Pend Oreille Telephone Companies
104 West Madison Ave.
Glenns Ferry, ID 83623

In addition, service of process may be made upon the Administrator.

Eligibility and Benefits
The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits and description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits
Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

Sources of Plan Contributions
Contributions to the Plan are made by the employer.

Medium for Providing Benefits
Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number SR-83116494 issued by Continental Casualty Company, CNA Plaza, Chicago, Illinois, 60685.

Date of End of Plan's Fiscal Year
The date of the end of each year for purposes of maintaining the Plan's fiscal records is December 31.

Claim Procedures

1. Presenting Claims for Benefits
   Claim forms may be obtained from: the Employer.

   Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

2. Claims Denial Procedure
   Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information *You* might be required to provide and an explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure. *You*, *Your* beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. *You* may have representation throughout the review procedure. A request for a review must be filed by 60 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 60 days after receipt of the request for the review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days after receipt of the request for the review. If such an extension of time is needed, *You* will be notified in writing prior to the beginning of the time extension period. The decision after *Your* review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

Statement of ERISA Rights
The statement of ERISA Rights is required by federal law and regulation.

As a participant in this Plan *You* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate *Your* Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of *You* and other Plan participants and beneficiaries.

No one, including *Your* employer, *Your* union, or any other person, may fire *You* or otherwise discriminate against *You* in any way to prevent *You* from obtaining a welfare benefit or exercising *Your* rights under ERISA.

If Your claim for a welfare benefit is denied in whole or in part, *You* must receive a written explanation of the reason for the denial. *You* have the right to have the insurance company review and reconsider *Your* claim.

Under ERISA, there are steps *You* can take to enforce the above rights. For instance, if *You* request materials for the Plan and do not receive them within 30 days, *You* may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay *You* up to $110 a day until *You* receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If *You* have a claim for benefits which is denied or ignored, in whole or in part, *You* may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if *You* are discriminated against for asserting *Your* rights, *You* may seek assistance from the U.S. Department of Labor, or *You* may file suit in a federal court. The court will decide who should pay court costs and legal fees. If *You* are successful, the court may order the person *You* have sued to pay the cost and fees. If *You* lose, the court may order *You* to pay these costs and fees, for example, if it finds *Your* claim is frivolous.

If *You* have any questions about *Your* Plan, *You* should contact the Administrator. If *You* have any questions about this statement or about *Your* rights under ERISA, *You* should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in *Your* telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
ERISA